### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Death 3. Time of Deeth erne 4e. Fecility Name (If not institution, give street and number) 4b. City\_Town, or Location of Death 1405 If Under 1 Year Months Days 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1 M 2 F 74 Yrs. 251-14-5202 IRGINIA Usual Rasidence of Decedant 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND 10e. Street end Number 10g. Citizen of What Country? 4225 AVENUE TON USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 14. Race - American Indian, Biack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK 3. Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Eiementary/Secondary (0-12) Coilage (1-4or 5+) 12 THGRADE LAUNDRY & DRY CLEANER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ALBERT CARRIE 19a. informant's Name/Raiationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Coda) 4225 HAMILTON AVENUE, BALTIMORE, MD. 21206 ce of Disposition (Neme of Date 20c. Location - City or Town, State VERNETTA MELVIN DAUGHTER 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetary, cremetory or other plece) 1 Buriai 2 Cremation 3 Removal from State ZION CEMETERY B-16-99 LANSDOWNE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility JOSEPH H, 2140 N, FULTO of Funeral Service Lie BROWN JR. FUNERAL HOME FULTON AVE, BALTIMORE, MD. 21211 10 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest heart failure. List only one ceuse on each lina. Immediete Cause (Final 9mo disease or condition resulting in death) as e consequenca of) Due to (or es a consequence of): Dua to (or as e consequance of): 23b. Did tobacco use contribute to the cause of death? YOS 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 Yes 1 Yas 2 No 25. Was case referred to medical

Physician /Medical Examiner

attending physicien and for usa as the burial-tran

signed by the a

peeu

After this certificate has

filled in by the funerel

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi

Attending Physician: or death.

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

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Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification:

Medical

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours eftar death with the Maryland nent of Health end Mental Hygiane.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours eftar death with the Marylan Depertment of Health and Mental Hygiane. Important: if itam 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at applied.

Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Diseese or Injury that initiated avants resulting in death) Lest

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

26. Place of Death (Check only one)

examiner? 1 Yes 2 No 27. Manner of Death

5 Panding Investigation

6 Could not be determined

28a. Data of injury (Month, Dey Year)

28b. Time of

28a. Placa of Injury - At home, farm, straet, fectory, office building, etc. (Spacify)

Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28c. fnjury et Work? 1 Yes 2 No

28d. Describe how Injury occurred

29a. Certifier (Check only one)

Naturai

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piace, end due to the ceuse(s) and menner es stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piace, and due to the cause(s) end menner stated.

29b. Signature and talle of certifier,

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stata)

31. Date filed (Month, Dey, Year)

32. Registrar's Signature

MAR 1 9 1999

30. Name and address of person wh



State Registrar



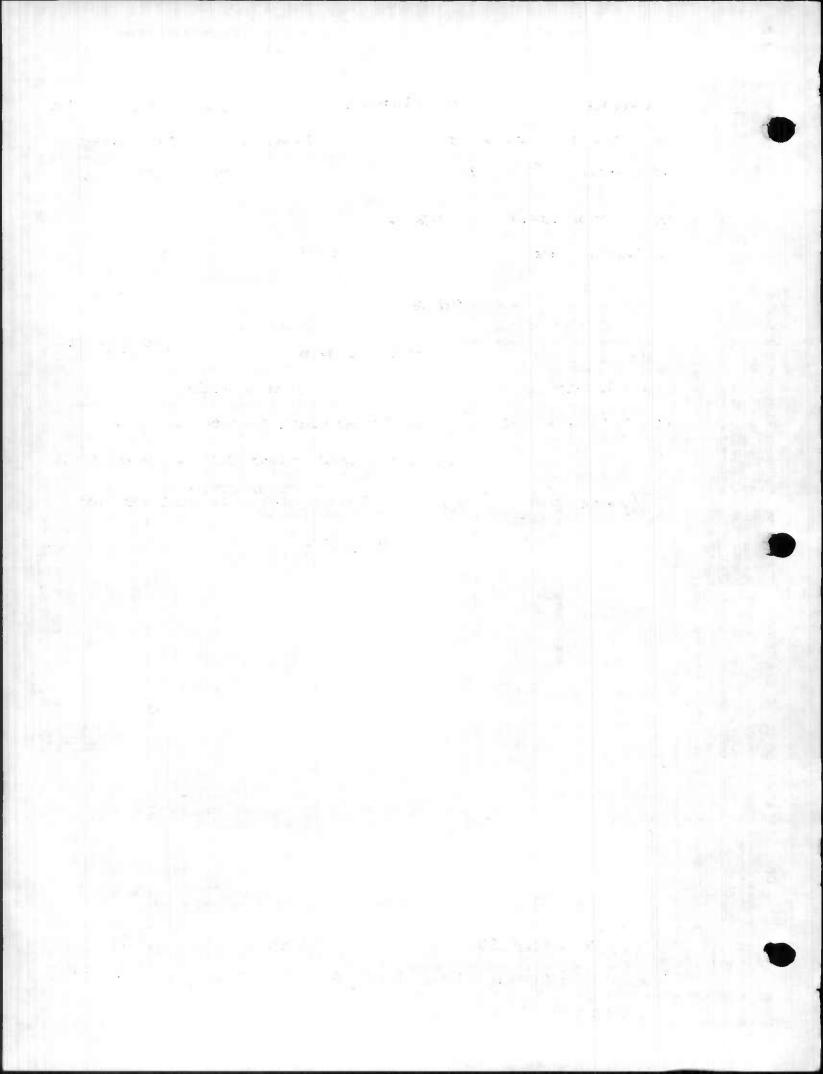
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Baltimore, Maryle permit. Pages 1 and 2 should Departmant of Haalth and Men Important: If Item 27 is marke any injury or other traumatic			Disposition  2 Cremation 3 Cremation 3 Cremation 3 Cremation 3 Cremation 3 Cremation 5 Crematical Series Crematical Seri			mont 1		ma of other place)  Data 20c. Location - City of Data 20c. Location - City of Davidsonv of Addrass of Facility						
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State Registrar

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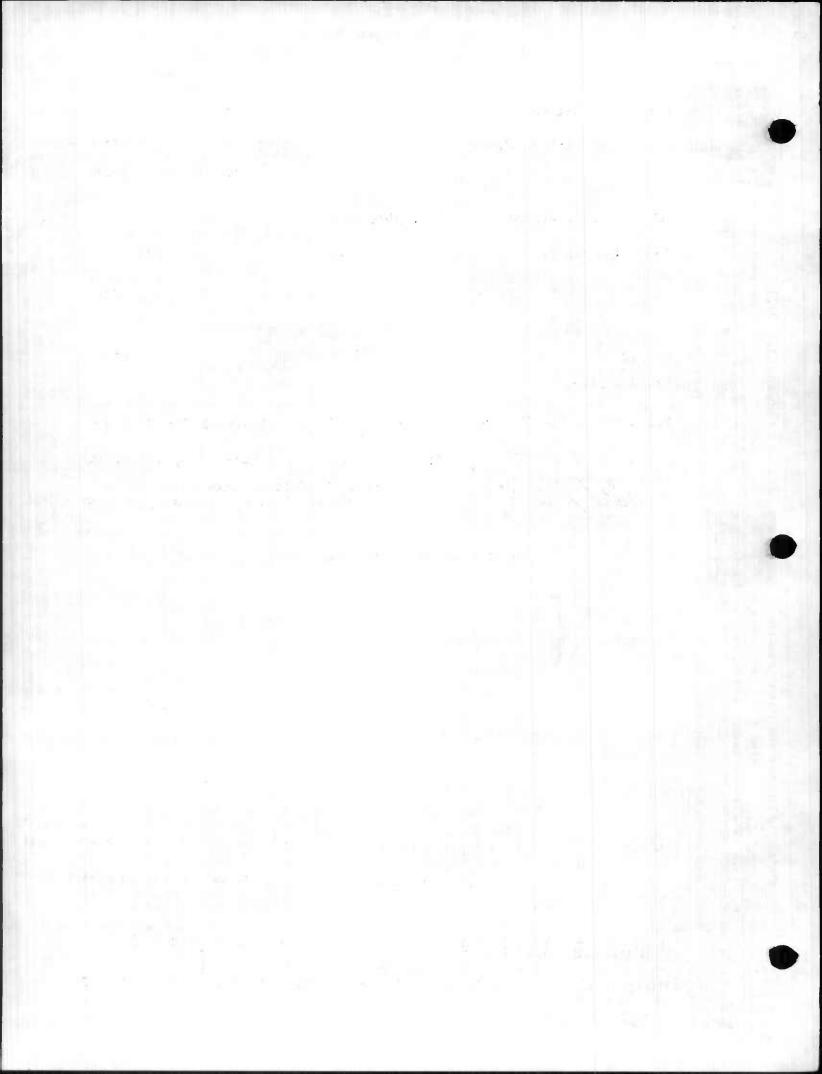
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

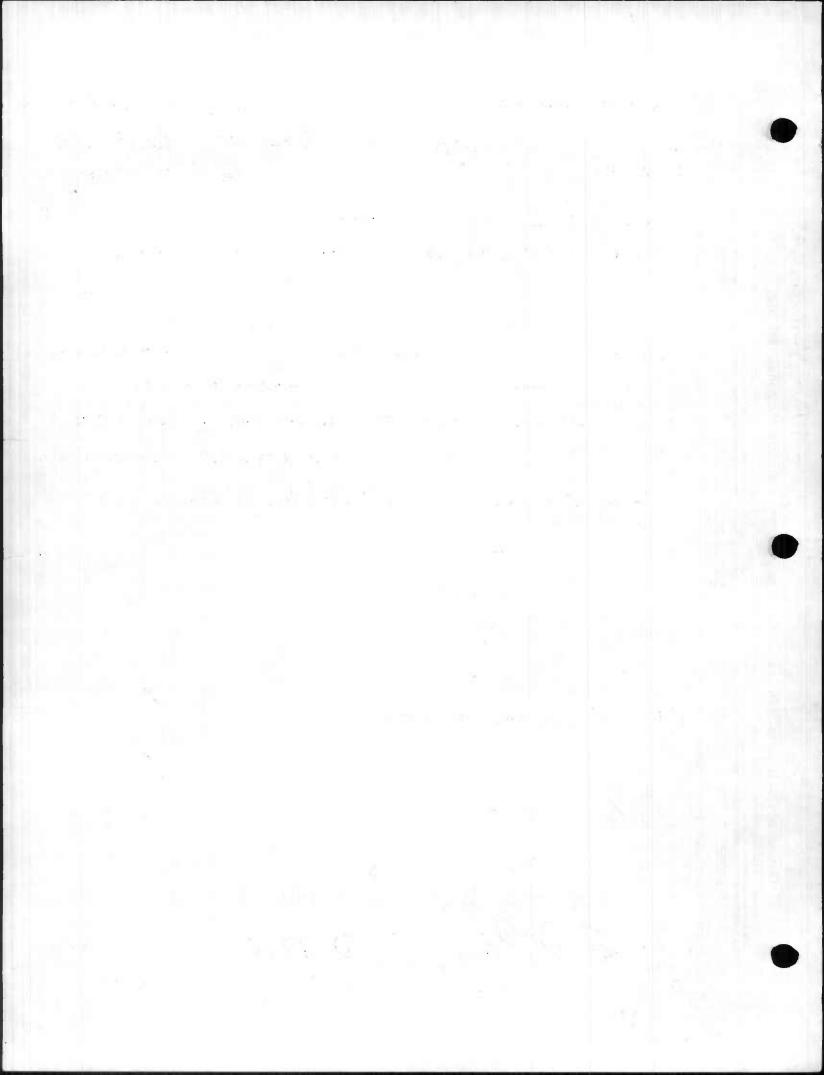
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Registrar



	Please Type or Prin State of Ma	ryland / Depa		lealth and Mental Hy	rgiene	00001.
Physician /Medical	Decedant's Name (First, Middle, Last)     Lillian Yokubinas	Cen	- 11	2. Data of Do Month	Day 1999	6:00 AM
Funeral Director	195-20-9574 1□M 2XF	(In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	It City, Town, or Location of Deal ROSS 4  If Under 24 Hrs. 8. Deta of Bi (Month, D) May 10	Boult orth av. Year) 9. B	ithplace (Stata or Foreign Country) Linns ylvania
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020 urs after death v al; or thems 23s amminer man	9512 Perry Hall Blud, Uni  11. Manital Status  12. Was Decedant E. Armed Forcas?  1 Naver Married 2 Married  3 Widowed 4 Divorced  12. Was Decedant E. Armed Forcas?  1 Yes 2 No. It Yas, Giva	var in U,S. 13. W	21236 las Decedent of H Yes, specify Cuba □ Yas 210 No	ispanic Origin? (Specify Yes or Nin, Mexican, Puerto Rican, etc.)  Specify:	U.S.A.  14. Race - An Black, Wt  Specify: U	narican indian, nite, atc.
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0 5 5 5	25. Wes case refarred to madical examiner?  1		28c. Injur Wor M 1	yet 28d. Describe k? Yes 2 No	idence 6 Other (Since how injury occurred	
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To the within 2 To the comple	29b. Signatura and title the print.  30. Name and address of person who completed causa of da		29c. Licens	a number +7746	29d. Data signed (Mc	onth, Day, Year) 8, 1999
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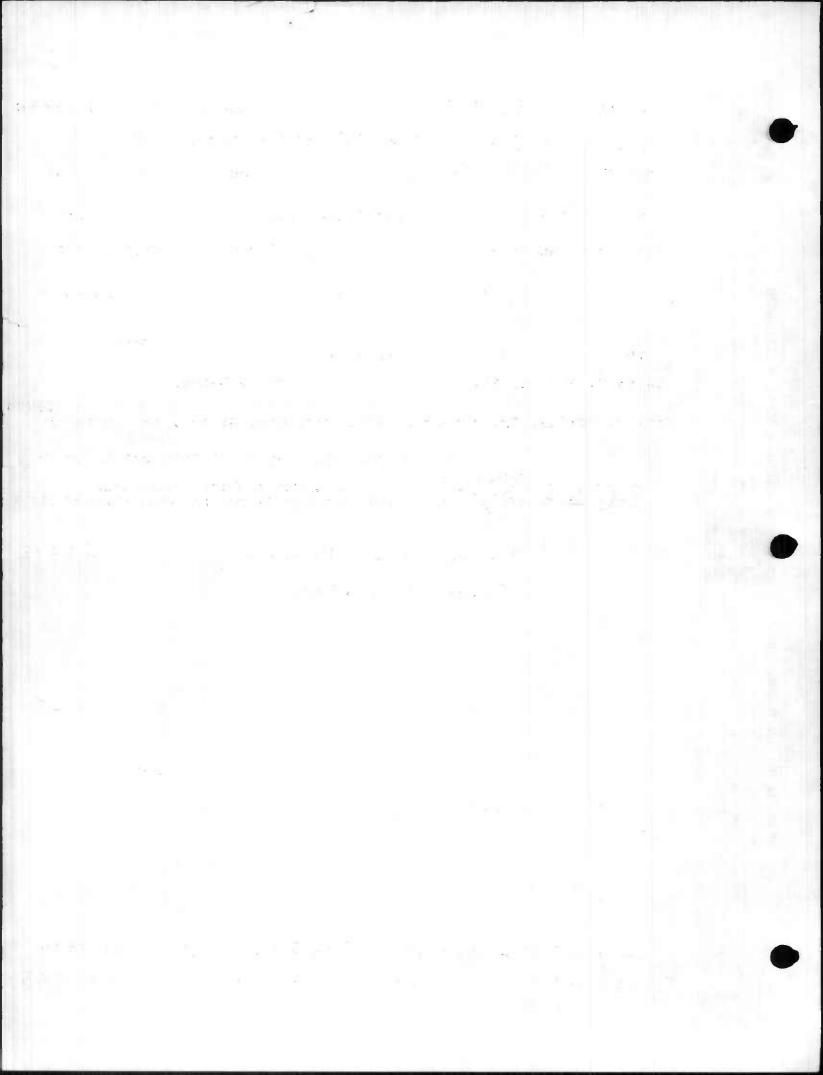
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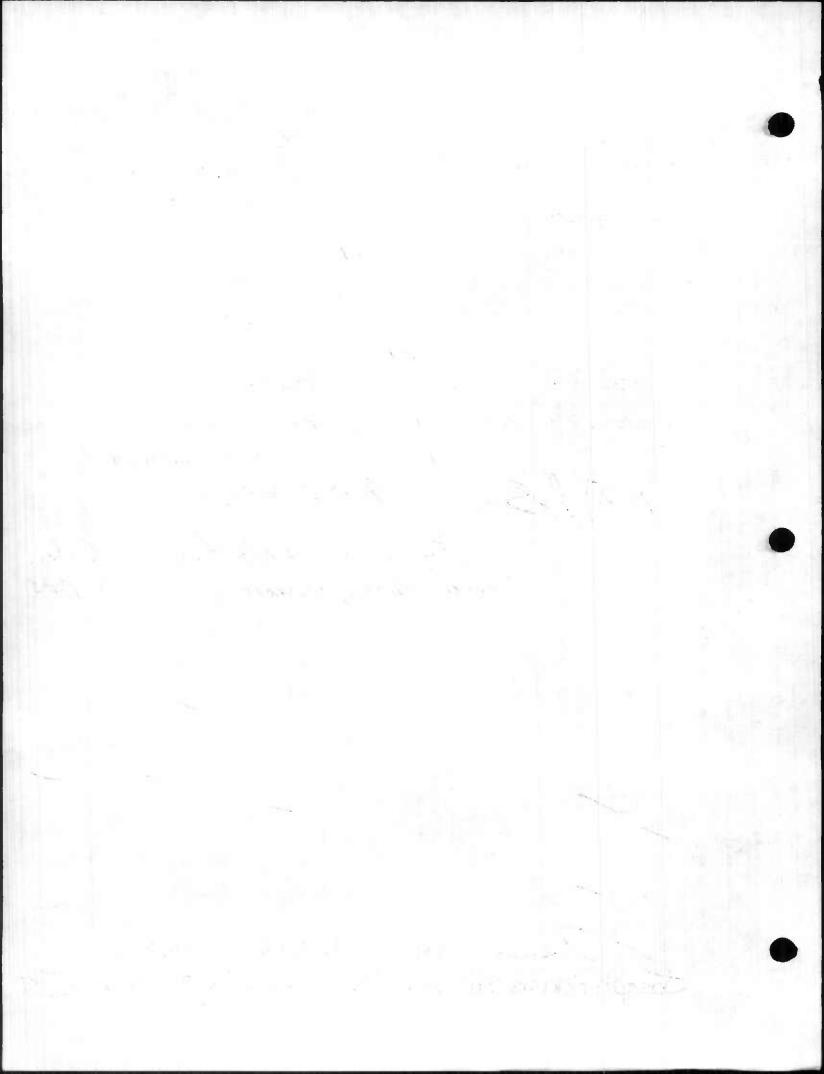
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Da Month Vest **Physician** ADKINS 11:32 A-M JAMES 21 March 1999 /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner BALTIMORE HARBOR

5. Social Security Number HOSPITAL CEN TER If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) 6 Sex **Funeral** Months Deys M 2□ F 404-34-3691 68 Yrs. **Director** KY Usuel Residence of Decedent tha Manyland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or hems 23s or 28s-f show traumatic event, the Maxical Examiner must be notified at Nes 2□No N/A Baltimore City MD Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1453 Covington Street 21230 United States death Funeral 14. Race - American Indien, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or He any Injury or other traumatic event, The Manital Engine. 1 ☐ Yes → No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: Specify: White þ 35 1 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Service 10 Painter 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be James S. Adkins, Sr. Menzie DeLong 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 21230 Carl R. Adkins, Sr. /Brother 1453 Covington Street, Baltimore MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Cem. March 22,1999 Baltimore City 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Cause (Finat 2 DAYS · Intracerebys! disease or condition resulting in deeth) Examiner Examiner Hernia requires that the death certificate be axecuted physician and the burial-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): usa as i jo signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Winknown þ 24b. Were autopsy findings aveileble prior to completion of cause of deeth? Completed 24e. Was an eutopsy performed? paga 2 s 2000 1 Yes 1 ☐ Yes 2 ☐ No cartificata Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Piece of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 UNG 2 ER/Outpatient 3 DOA After this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Naturel 5 Pending 1 ☐ Yes 2 No 24 hours after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 ☐ Homleide Hospital i 🗓 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and manner es stated. 29a. Certifier Medical complataly (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 \$ 29d. Dete signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number March 21, 1999 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 3001 S. BALTIMORE, MO 21225 HANOVER ST. BOBAT ISMAIL 31. Dete filed (Month, Dey, Yeer) 32. Registrar's Signature State MAR 2 2 1999 Registrar



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

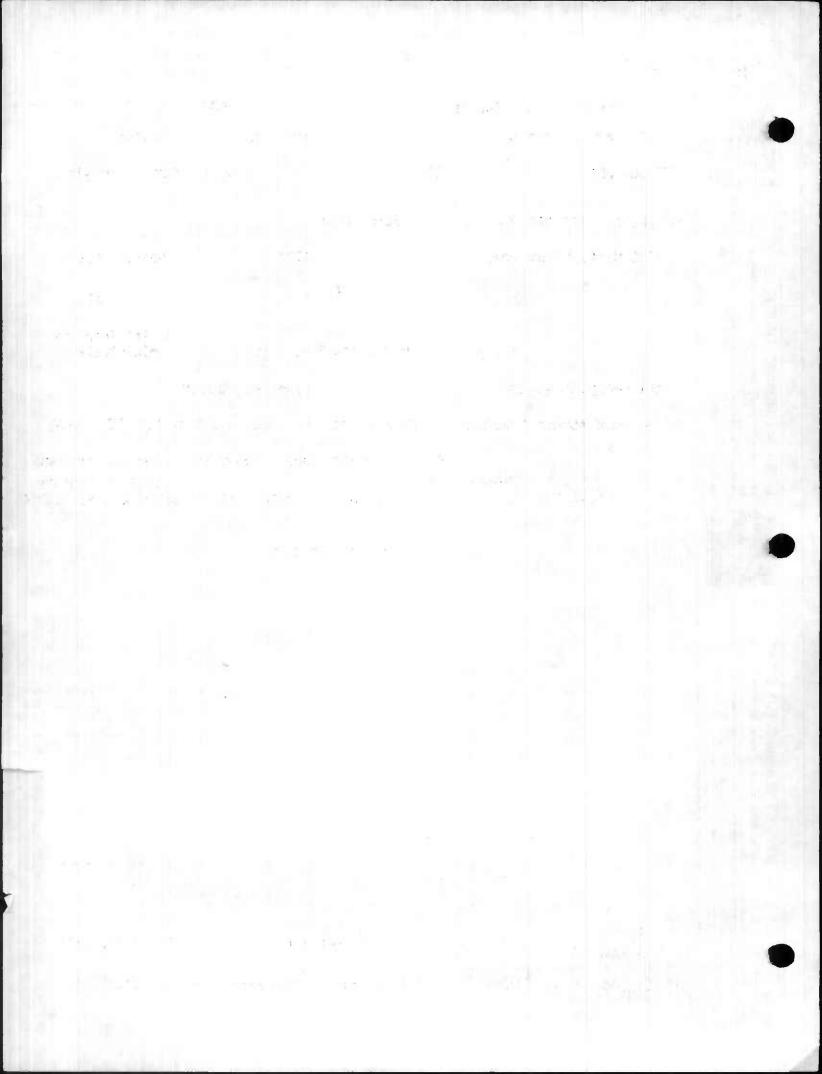
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Year Month **Physician** Ruth Adams March 17, 1999 11:16AM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Blakehurst Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) **Funeral** Deys Months Hours 220-46-4129 1□ M 2 F Yrs. 88 Director March 08, 1911 Maryland Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 West Joppa Rd. 21204 USA Funeral death 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, 11. Meritel Status Bleck, White, etc. filed within 72 hours after 1 Yes 2X No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Merried aitimore, Maryland 21215-0020 1 ☐ Yes 2 🔀 No Specify: Specify: by 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bustness/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) pemit. Pages 1 and 2 should be filled w Department of Health and Mental Hygier Important: if Item 27 is marked other th eny Injury or other treumatic event, the +4 Homemaker Own Home 17. Father'a Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be George Edward Markley Edna Penn 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 11527 Falls Rd. Lutherville, MD. 21093 Mr. Thurston R. Adams, Jr./Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ₺ Buriel 2 Cremetion 3 Removel from Stete Parkwood Cemetery 3-20-99 Baltimore, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Lic 22. Neme end Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 23a. Part. Enter the data se, or compositions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner an Tev. attending physician and for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditiona, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical the Due to (or es e consequence of) 88 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 No 2 No 3 Probably 4 Unknown bengis d be del þ Records, 24b. Were autopsy findings available prior to completion of cause of death? been si 24a. Was en autopsy performed? Completed page 2 s 1 Yes 2 No 2 No certificate Division of Vital Hospital or Attending Physician: 24 hours efter death.
Funerel Director: After this certifica etely filled in by the funeral director. 8 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 100 Menner of Death 28e. Dete of Injury (Month, Dey Year) 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Time of 1. Netural 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide To the Hospital or A within 24 hours effer To the Funerel Dire completely filled in b 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. 29b. Signeture end title of certified 29c. License number 29d. Dete signed (Month, Dey, Year) m 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print 32. Registrer's Signeture State MAR 22 1999 Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEMS: #23	ABRAMS PART i, 27, 28A-F PER 1. Decedant's Nama (First, Middla, La		9 WR.Ce	rtificate of	Death	2. Dete of D	Reg. No.		3. Tima of Death	
Physician - /Medical	Christine	R. Abrams				Month MARCH	1 18, 19	Year 999	2210 PM	
Examiner	4a Facility Nama (If not institution, give 2308 HARVEST FA				4b. City, Town SYKESV	or Location of Dea	th 4c. County CARRO			
Funeral Director	220-50-1061	Det offic	last birthday) O Yrs.	If Undar 1 Yaar Months Days	Hours Min. (Mont		sta of Birth onth, Day, Year) 0/12/1948 9. Birthold Count May		a (Stata or Foreign yland	
rms 23a or 28a-f show crivial be notified at neral Director	That J = dille	10c. Ci	ly, Town or Lo	/kesville			100 Citizen of N		Insida City Limits	
Fr. or its	10e. Street and Number  2308 Harvest Fa  11. Meritel Status  1 Never Marriad 2 Merried  3 Widowed 4 Divorced	12. Was Decedant Evar in U Armed Forcas? 1 ☐ Yas 2 12 No If Yes, Give Yaar or Datas:		Wes Decedant of If Yas, specify Cub		Unit	United States  14. Rece - American Indien, Black, White, atc.  Specify: White			
Mental Hygiene.  arked other than "naturalitic event, the Medical To Be Completed	15. Decedent's Ec (Specify only highast gra Elemantary/Secondary (0-12)	ucation da complated) Collega (1-4or 5+) 4 yrs.	(Give	dant's Usual Occu kind of work dona DO NOT use ratire	during most of d)		Socia	Kind of Business/Industry Social Security Administration		
	17. Fathar's Nama (First, Middla, Last) Paul George Ring  19a. Informant's Name/Ralationship (	rose	19h Maili	ng Address /Stree	Ther	Name (First, Middle esa Knau or Rural Routa Num	ier		orde)	
Heelth ar om 27 is ther trau	Mr. Richard Abram  20a. Mathod of Disposition  1 Burial 2 Ø Cramation 3 □	s / Husband	2308 Placa of Dispo	Harvest position (Nama of matory or other pla	Farm R		cesville	, MD 2	21784	
Department of Important: if its any injury or o once.	4 Donation 5 Othar (Specify	) H		Service 2. Nama and Addr. LEONARD	ass of Facility	03/23/9	530	5 Harf	aryland ord Road ND 21214	
ettending physician and and an and an and an and an	shock, or heart failure. List only  Immediata Causa (Final disease or condition rasulting in death)  Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disease or injury that initiated evants rasulting in death) Lest	e. ALCOHOL Due to (d	AND CLOM or as a consecutive c	quanca of):	NTOXICAT	ION			tarval Batwaan nset and Deeth	
for t	Part II. Other significant conditions o	ontributing to death but not res			ontributs to the cause of death?					
rate hes been signed by the page 2 should be detached Completed by Physic						24a. Wa	as an autopsy formed?	availa	autopsy findings able prior to lation of cause ath?	
is certificate he director, page							Yas 2□No	1 🗆 Y	′as 2□ No	
this certific ral director,	25. Was casa rafarrad to medical examiner?  XXYes 2□ No	Hospital: 1   Inpatiant 2	TER/Outpaties	nt 3 DOA OI	har	Daath (Check only		ar (Specify)		
h. After thi funeral funeral	27. Mannar of Death  1 Natural 5 Panding 2 Accidant invastigation	28a. Date of Injury (Month, Dey Year) Found: 3-18-99	28d. Dascribe UNKNOWN	Home XX Rasidanca 6 □Othar (Specify)  28d. Dascribe how Injury occurred  UNKNOWN						
al Direct led in by	Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner as steted.									
within 24 hou To the Fune completely fil	(Check only one) Medical Example 129b. Signature and titla of cartifiar	inner: On the basis of examine and manner stated.	ation and/or In	vestigation, In my 29c. Licen	opinion, deeth	occurred at tha time	a, data and placa, 29d. Date signe	and due to th	ne cause(s)	
()	30. Nama and addrass of person who	completed cause of death (Ital)		Print)		imore, Ma				

Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Dete of Deeth 3. Time of Death Month **Physician** 35AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street end number) Examiner OUSON Under 24 Hrs. 8. If Under 1 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex **Funeral** Deys 8 07-9072 15 M 2 F Director Pennsylvania Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "netural", or items 23s or 28s-f show any Injury or other treumatic avent, the Medical Evantinet must be notified at page. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street and Number 21286 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 1 Yes 2 No It Yes, Give Yeer or Detes: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify þ 3 Widowed 4 ☐ Divorced Completed Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry JULIO + JONS Elementery/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be NICOLO 0 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 2/222 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 20e. Method of Disposition March 23 1 MBuriel 2 ☐ Cremetion 3 ☐ Removel trom State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Furthral Service Lice 22. Name end Address of Fecility Funeral Chapel vans Hartord ill Rd 21234 Approximete Intervel Between Onset end Deeth 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Physician Immediete Cause (Finel per St. Vosqu's ER physician diseese or condition resulting in deeth) **Examiner** Due to (or es e consequence ot) Dizease Cerebro UUZCU br ettending physician and for use as the bunal-transit Sequentielly list conditions, if eny, teeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence ot) Physician/Medicai Due to (or es e consequence of) Atrial fibrillation 88 signed by the etter d be detached for 23b. Did tobacco use contribute to the cause of death? Pert il. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i 1 No 2 No 3 Probably 4 Unknown by 24b. Were autopsy tindings eveileble prior to completion of cause of deeth? Be Completed 24e. Wes en eutopsy After this certificate has been s funeral director, page 2 should 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 25 No 1 tnpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 28d. Describe how injury occurred Certification: 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28b. Time of 1 Neturei 2 Accident 5 Pending investigation 2 No 1 Yes 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician:

death with the Maryland

Baltimore, Maryland 21215-0020

completely within 2

after death. 24 hours after death

> State Registrar

Medical

29b. Signeture end title of on

iner: On the besis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

we 102 Towson,

50859

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Neme end eddress of person w of deeth (Item 23e) (Type, Print)

ORK

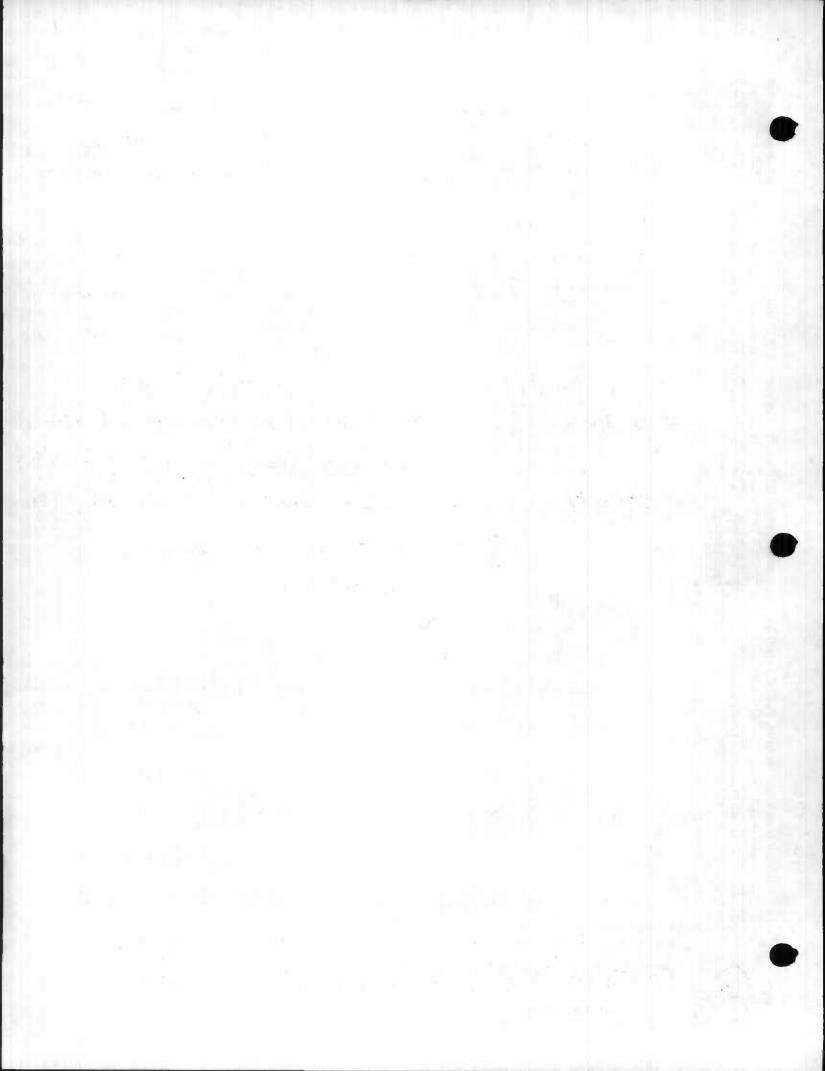
moth 78 Would 31. Dete filed (Month, Dey, Year)

MAR 2 2 1999

4 Homicide

29a. Certifier (Check only one)

32. Registrer's Signeture



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician March 1999 Joan T. Bennett 7:05 am. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Multi Medical Center Tewson Baltimore If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Mary Tand Months 1□M 20 F 214-28-8724 67 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location show. 1 Yes 2 No Maryland Carroll Westminster Directo "natural", or items 23s or 25s-f must be notif 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 490 Pinehurst Circle U.S.A. 21158 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Yaar or Detes: 14. Race - American Indien, 11. Merital Status Bleck, White, etc. 72 hours after 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry filed within Hygiens. Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Homemaking 17, Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 88 Pages 1 and 2 should be need of Health and Mental in them 27 is marked or John William Tieder Isabel Tubman 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Stan Bennett - son 26900 West hazen Rd. Buckeye, Arizona, 85326 20b. Plece of Disposition (Name of cemetery, cremetory or other place)
Metro Crematory 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from Stete March 24, 1999 Baltimore. Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecifity Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, Md. 21102 23e. Pert1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona causa on aech lina. Approximete Intervel Between Onset and Death Physician /Medical Immediete Cause (Finel disease or condition resulting in deeth) Examiner Examiner physicien end s the burial-transit that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting In death) Lest Box 68760. Physician/Medical Due to (oras a conattending p 88 0 980 ed by the detached Pert ff. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 4 Unknown 1 Yes 2 No 3 Probably by cate hes been significant category. 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 1 Yes this certificate Division of Vital Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mepper of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Panding investigation within 24 hours after deeth.

To the Funeral Director: Afte completely filled in by the fur 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide ŏ 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated. 29a, Certifier (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 0 30. Nema end address of person who completed cause of deeth (Item 23a) (Type, Print) 22. Registrar's Signature State Registrar

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 1999 Verlie Allan Benge March 14, 18:00 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4127 Schalk Road Millers Carroll 8. Data of Birth
(Month, Day, Year)
Tine 15, If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country)
Pa 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 215-64-1668 107M 20 F 42 1956 Director Usual Rasidence of Decedent the Menyland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Md. Director Carroll Millers 10a Street and Number 10f. Zip Code 10g. Citizan of What Country? 4127 Schalk Road #1 21102 U.S.A. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indien, 11. Marital Status Black, Whita, atc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Aq 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "I any Injury or other traumatic event, the Nex Elementary/Secondary (0-12) College (1-4or 5+) 1 Factory Worker Sheet Metal 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 8 Verlin Dallas Benge Mayfield Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Benge - wife 4127 Schalk Rd. #1 Millers, Md. 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Deta 20c. Location - City or Town, Steta Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Marks Ch. Cem. March 18, 1999 Snydersburg, Md. 22. Name and Addrass of Facility
Eckhardt Funeral Chapel 21. Signeture of Funeral Service Licenses 3296 Charmil Md. Dr. Manchester, 21102 23a. Pert1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final Atheroscienatic Cardiovascular disease disaasa or condition rasulting in death) Due to (or as a consequence of) Examiner siclan and burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760, Physician/Medical Due to (or as a consequence of): attending signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? been si 24a. Was an autopsy performed? Completed 1 ☐ Yas 2 No 1 ☐ Yas 2 No Division of Vital 25. Was casa refarred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: 1 | Inpetient 2 | ER/Outpetient 3 | DOA Other: 4☐ Nursing Homa 5屆 Rasidence 6 ☐ Other (Specify) 1 XYas 2 No P this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural al or Attending after death. 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

Wild call Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifiar Medical (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signeture and titla of certifier O.C.M.E MARCH 16, 1999 MD 30. Nema and addrass of person who completed cause of death (trem 23a) (Type, Print)

State

Registrar

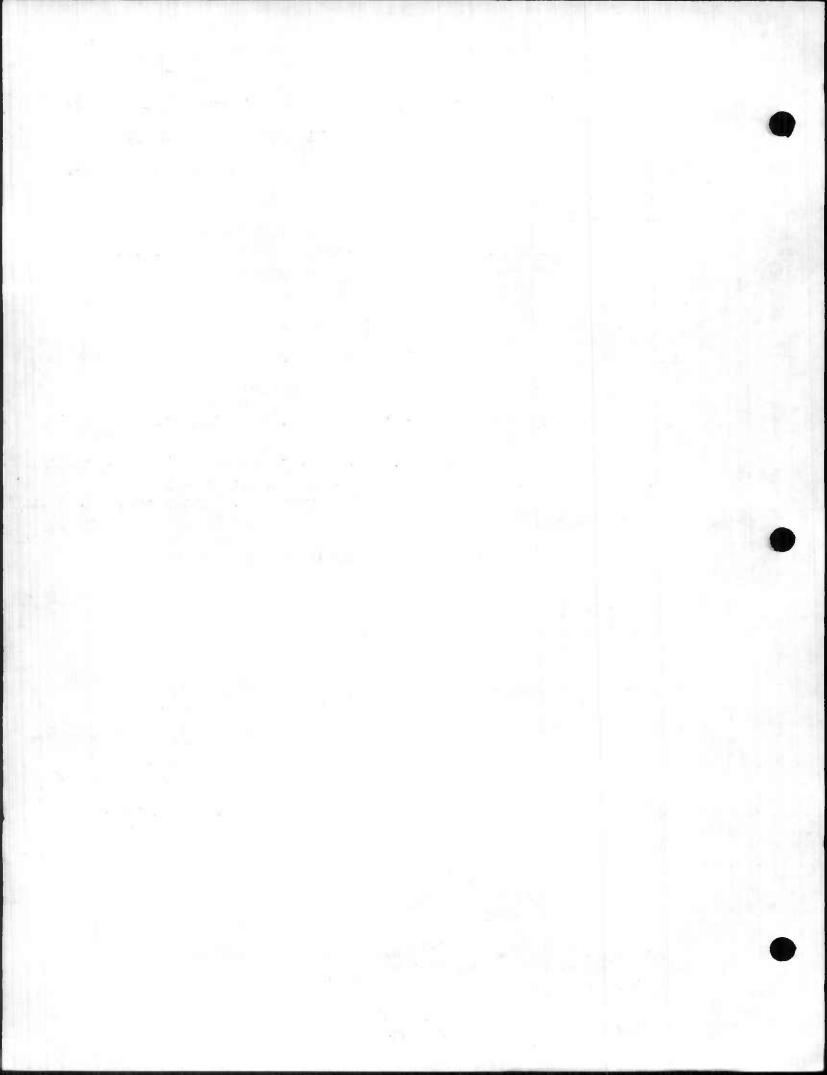
MAR 2 2 1999

Radentz

Stroben S, 1 31. Data filed (Month, Day, Year)

32. Registrar's Signature

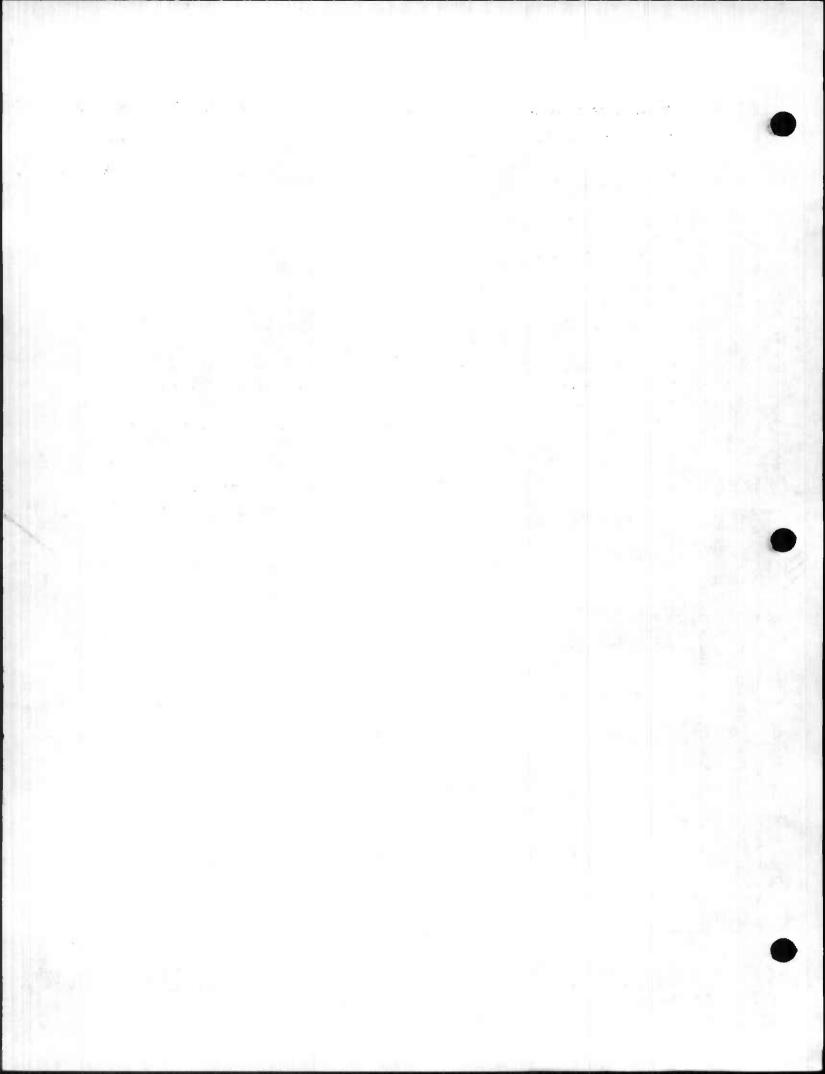
111 Penn Street, Baltimore, Maryland 21201



### Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day Year **Physician** March 18 1999 12:10 P.M. Edith Pamela Baxter /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15 Bethayres Court Montgomery Derwood # Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 9. Birthplace (Stata or Foreign Funeral Days Months Hours 10 M 20 F 212 54 7080 51 June 16,1947 Washington D.C. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yas XIX No Director Montgomery Maryland Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WITH ŏ 15 Bethayres Court 20855 United States permit. Pages 1 and 2 should be filled within 72 hours after death v Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural". or least in high or other traumatic avaination. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2⊠ No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11 Marital Status Black, Whita, atc 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: p 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Horse Trainer Private 17 Father's Nama (First Mirirlla Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be John B. Edwards Ingrid E. Larson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Son Kirk G. Baxter 15 Bethayres Ct. Derwood Maryland 20855 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 20b. Place of Disposition (Nama of cematary, crematory or other place) March 24, Dstq 999 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Other (Specify) Alexandria Virginia Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be asscuted burial-transit Sequentially list conditions, if sny, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events pue Due to (or as a consequence of) physician the burial Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) for use as 88 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 100 signed by t d be detach 2 X No 3 Probably 4 Unknown 1 ☐ Yas Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Deen page 2 s has 2 NO 1 ☐ Yas 2 ☐ No certificate Attending Physician: 25. Was casa referred to medical examiner? Be 28. Placa of Death (Check only ona) 1 Yas 2 No Other: 4 Nursing Homa Statement 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this s funaral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury st Work? After Natural 5 ☐ Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun. 1 □ Yas 2 □ No 2 Accident invastigation 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide edicai Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar as stated. ner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha time, data and placa, and dua to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cert 29d. Data signed (Month, Day, Year) 30. Name and address of pe who completed cause of death (Item 23a) (Type, Print) 31. Data filed (Month, Day, Year) MAR 2 2 1999 32. Registrar's Signature State Might Registrar



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death BURKE Month MARCH 1999 H. WILLIAM 1335 hrs. 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death SALEIMORE, CITY If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) BAltimore IHE JUNNS 5. Social Security Number 7. Age (In yrs. last birthdey) Birthpiace (Stete or Foreign Country) XXM 2□F Months Days 045 22 3269 69 7, 1929 Connecticut Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1701 Swinburne Ave. 21114 United States 12. Was Dacedant Evar In U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) Race - American Indien, Bieck, Whita, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No if Yes, Give XX Year or Detes: 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Broker Real Estate 12 18 Mother's Name (First Middle Maiden Sumema) 17. Fathar's Name (First, Middle, Lest) William Harold Burke, Sr. Catherine Marie Bowler 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Burke Wife 1701 Swinburne Ave. Crofton Maryland 21114 20b. Place of Disposition (Name of cametery, cremetory or other place) March 14pate 199920c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 ☐ Sremation 3 ☐ Removal from Stata The Huntt Crematory Waldorf Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23a. Partl. Enter the disease, or complications that caused the deeth. Do not anter tha moda of dying, such as cardiac or respiratory arrest, Interval Interval Robert E. Evans Funeral Home, Inc. Approximate Interval Between Onsat and Death immediete Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE ONE DAY UNCERTAIN CANCER LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown COPD 24b. Were autopsy findings available prior to complation of cause of death? 24e. Wes an eutopsy performed? 1 Yas 2 No 1 Yes 2 No

**Physician** /Medical **Examiner** 

certificate be executed

P.O. Box 68760

Division of Vital Records.

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

10

**Funeral** 

Director

tem 27 is marked other than "naturel", or tems 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heelth and Mentel Hygiene. If them 27 is marked other than "natural" and virjury or other traumatic even.

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Examiner Physician/Medical þ Completed Be 10

Certification:

Medical

29b. Signature

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24 hours a Funeral D Hospital completely within 2 \$ 0

25. Wes case referred to medical examiner? 28. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturei 2 Accident 5 Pending investigation 1 TYes 2 □ No 6 Could not be determined Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Piace of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier (Check only one)

MEDICAL RESIDENT

29c. License number P11702 29d. Date signed (Month, Day, Year)

MARCH

30. Name and address of person who completed cause of death (item 23a) (Type, Print) GOD NORTH WOLFE STREET BALTIMORE 21287

MBONU, MD

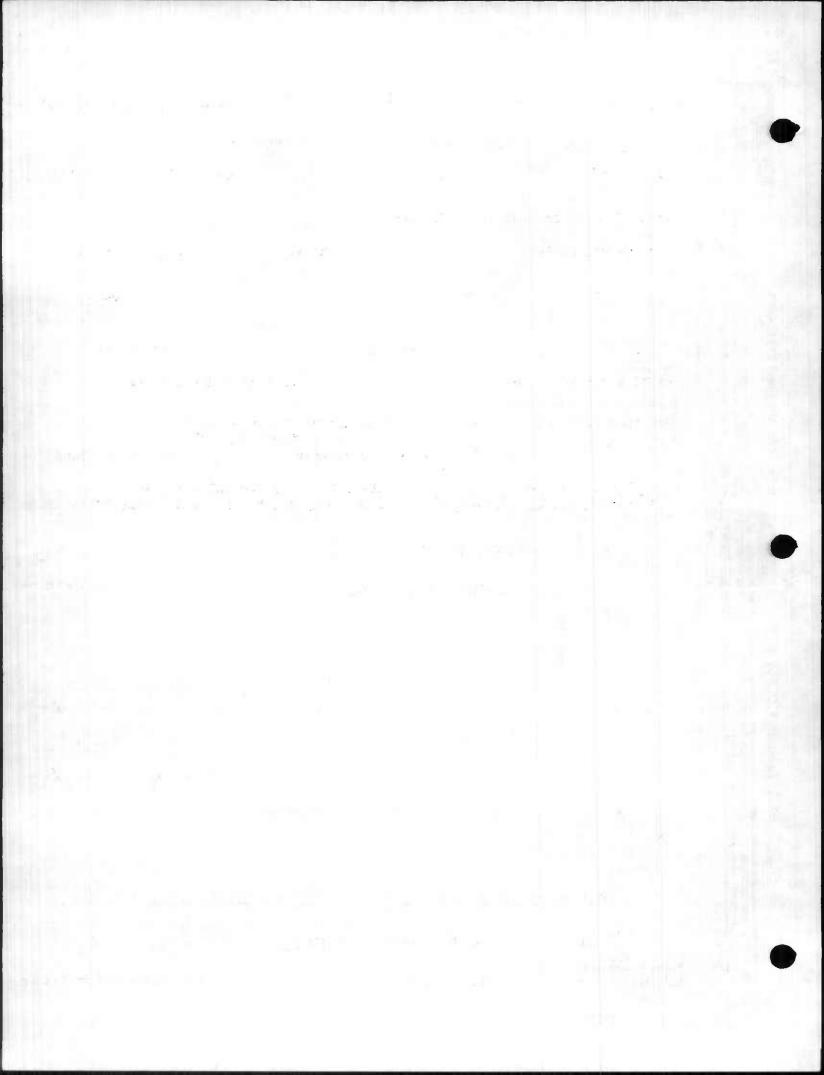
31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signature

MAR 2 2 1999

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**DHMH 16 Rev 6/95** 

Registrar



Examiner The law requires that the death certificate be executed P.O. Box 68760,

Examiner Physician/Medical þ Completed Be 2 Certification:

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

Completed

Be

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**Funeral** 

Director

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental hygiene. Important: If Itam 27 is marked other than "naturel", or Items 23s or 28s-f show any injury or other traumstic event, the Medical Examiner must be notified at

Important: If any injury o pnce.

**Physician** 

/Medical

physician and s the buriel-transit 60 USB signed by the e Division of Vital Records, been sig certificete has b lirector, page 2 st After this or Attending deeth. efter deeth Director: in by Hospital 24 hours To the I within 2

State Registrar

Medical

31. Date filed (Month, Dey, Year) MAR 2 2 1999

4 Homicide

(Check only one)

29b. Signature end title of certified

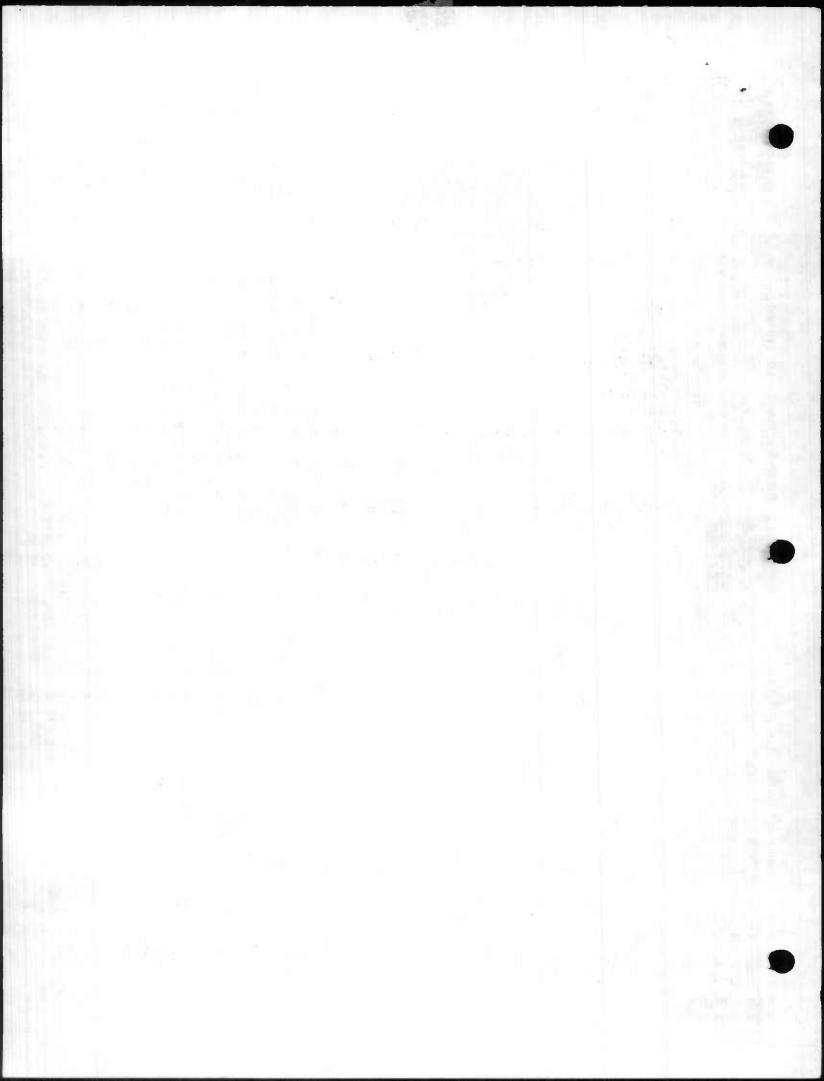
imm our 30. Name and address of person who/complated cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

29c. License number D45554

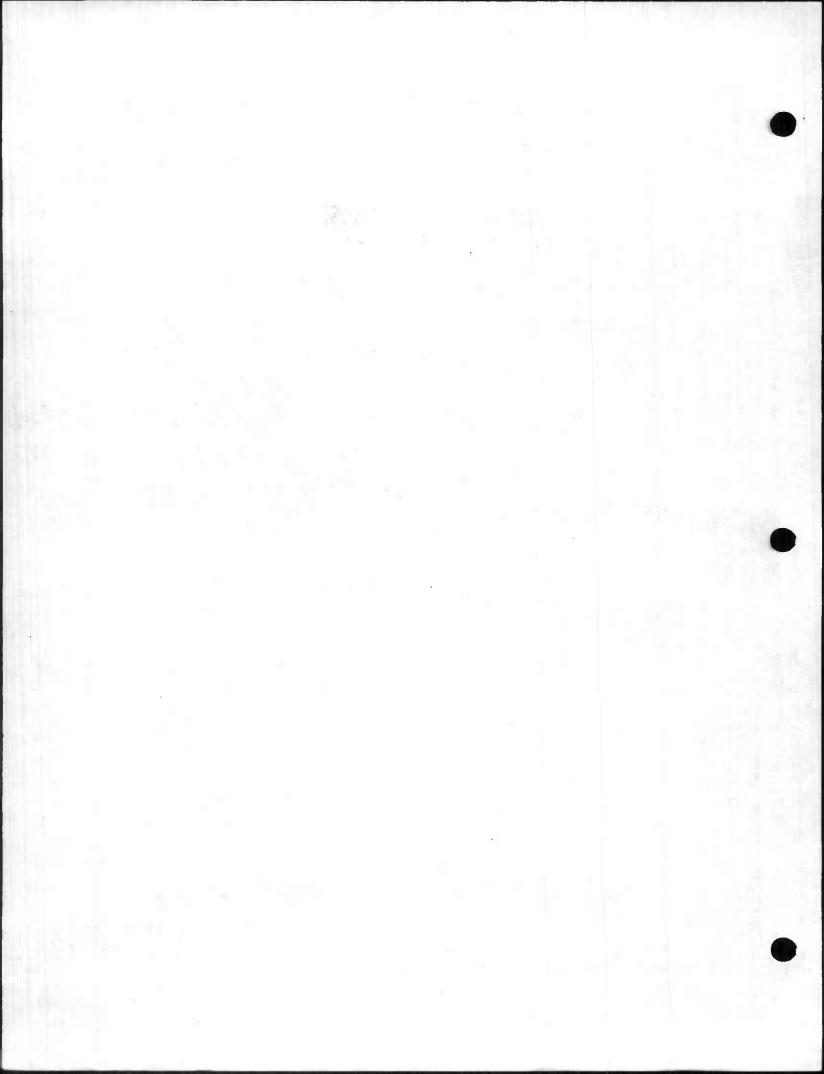
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29d. Date signed (Month, Dey, Year) March



			epartment of Health and Certificate of Death	Mental Hygiene	09014			
Physician /Medical	Decedent's Name (First, Middle, Last)     Leonard     As Facility Name (If not institution, give s	Corneliu	15 4b. City, Town,	2. Date of Death Month Day MARCH 19 or Location of Death 4c. Cour	Year 3. Time of Deeth 11:55 A.M.			
Funeral Director	NoRTH ARUND	FL HOSPITAL  7. Age (In yraylast birth	day) If Under 1 Year If Under 24 H Months Days Hours M		SE ARUNDEL  9 Birthplace (Stelle or Foreign  5 Carolina			
death with the Maryland ore 23e or 23e-f show creat be notified at	10a State 10b. County Anne A	rundel Gler	or Location BUMPIE		10d. Inside City Limits 1 ☐ Yes 2 No			
deeth with the Marine 23e of 28e f a	109 Arunde	1 Corp. Rd.	2106 /	U.	5. H.			
0020 bure after death w rati, or theme 23a Estiminar must I by Funeral I	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces?  1  Yes, 2 WNo If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu  1 ☐ Yes 2 ☑ No Specify:	(Specify Yea or No- erto Rican, etc.)	lace - American Indien, Bleck, White, etc. city: Black			
ind 21215-0020 be filed within 72 hours after tel Hygiene. d other than "natural; or he avent, the Medical Examina Be Completed by Fu	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) (	Decedent's Usual Occupation Give kind of work done during most of v life, DO NOT use retired)		Business/Industry			
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e, Mg	19a Información Name Relationship (19)  1	US -WIFE 10	Mailing Address (Street and Number er  Disposition (Name of Disposition	rp. Ra. Ba	m, State, Zip Code)  110 MD 2106  n - City or Town, State			
Baltimore, permit. Pages 1 a Capariment of Has Important: If Nem and Information of the ance.	1 Burial 2 Oremation 3 R. 4 Donation 5 Other (Specify) 21. Signature of Fuheral Service Ucense	Ceau	, crematery or other place)  22. Name and Address of Facility	7/25/99 Glas	BURIE MY			
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Physician /Medical Examiner	Immodate Cause (Final disease or condition resulting in death)	SEPSIS  Due to (or es a co	onsequence of):		Chast and Double			
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876( mysicia the bur	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
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F 5 50 F	1 Yes 20 No "  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28e. Date of Injury 28b. Ti	patient 30 DOA 40 Nursing	g Home 5 Residence 8 0				
Divis	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, ferr building, atc. (Specify)	m, street, fectory, office	28f. Location (Street end Number or Rurel Route Number, City or Town, State)				
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To the He the comple	29b. Signature and title of continue	and morniol states.	29c. License number	29d. Date sig	gned (Month, Day, Year)			
1/2	Azat in	Mb.	D4397-	7 Maril	4 19 1999			
11/1/	30. Name and addition of person who cou	mpleted cause of deeth (Item 23a) (1	ype, Print) De Bruce.	ms mn 2	10 61.			
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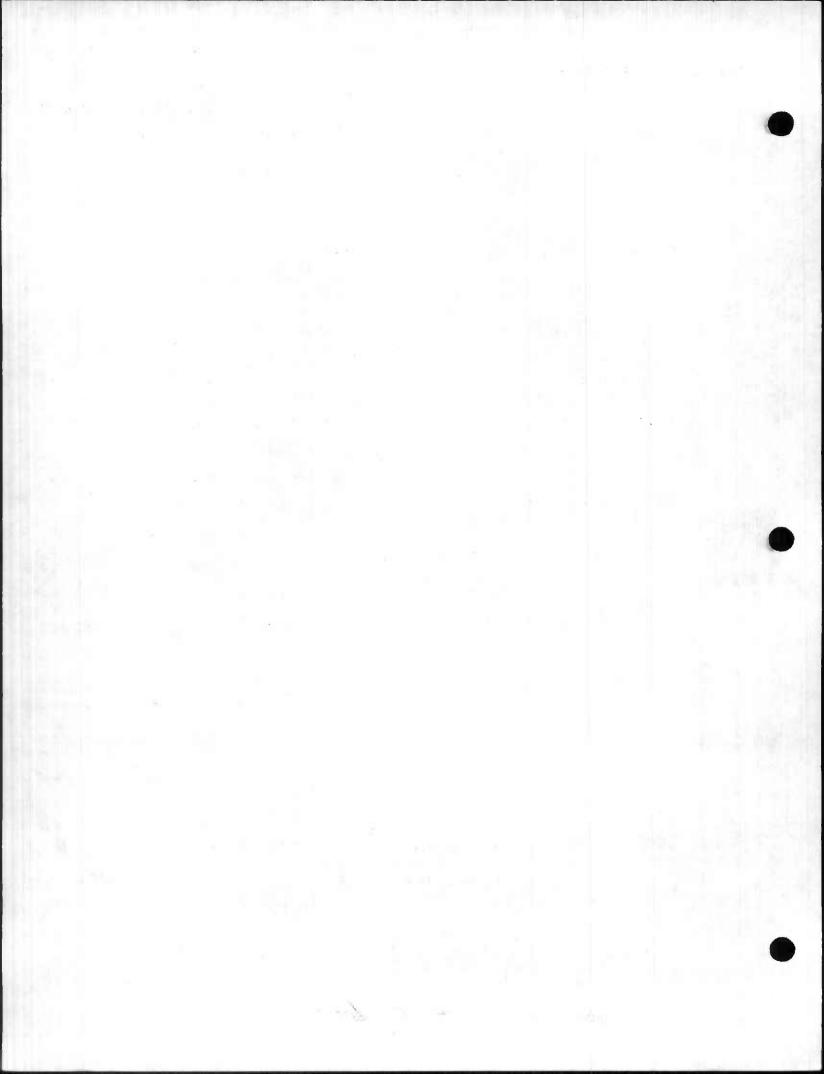
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEMS: #26, 28B, PER MD G769 3-22-99 WR. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Year **Physician** Ruth J. Cross 7:20PM March 14, 1999 /Medical 4a Facility Neme (If not institution, give street end number)
Howard County General Hospital 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Columbia Howard 5. Social Security Numbe 478-26-2027 If Under 1 Yeer If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct. 21, 1913 **Funeral** Deys Months Hours 1 M 28 F Yrs 85 Iowa Director Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits MD Howard Columbia 1 TYes 2X No Directo 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 9603 Quarry Bridge Court 21046 USA Berrs 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck. White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Merried 8 altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 ☐Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Purchasing Agent U.S. Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Is marked of 8 Joseph Box Margaret Williams Pages 1 and 2 should 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health reportant: If Item 27 I Ralph Cross (Son) 7018 Deepage Drive, Columbia, Maryland 21045 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Columbia Memorial Park 3/17/99 Clarksville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facilit Witzke FUneral HOmes, 21. Signeture of Funeral Service Licenses 5555 Twin Knolls Road, Columbia, MD 21045 23a. Part1. Eliter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical immediate Cause (Finel Internal diseese or condition resulting in deeth) Examiner Due to (or as e consequence of). Examiner Pelvis phour tracture physician and s the bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Motor Vehicle Accident Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of): Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 40 3 Probably 4 Unknown chronic atrial febrillation, congestive signed t by 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes en autopsy performed? Completed ailure, hypothyroidism, hlo gout Mo gastrice + chronic renal failure 1 Yes 2 DNo 1 Yes 2 No ulcer, anemia To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Nes 2 No Be 26. Place of Deeth (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 27. Menner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Natorel auto accident 1 Yes 2 No 2 Accident mar 14,1999 9:30 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number City or Town, State) 4 Homicide Snowden River + Ozkland Mills Rd readside - auto accident -1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 295. Signeture and title of certifie 29c. License number 29d. Dete signed (Month, Dey, Year) Mar 16, 1999 MND 21042 30. Name and address of person who completed gause of deeth (Item 23e) (Type, Print) PATRYCE A. TOYE, 4565 Hemlock Cone Way MID Mn 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar MAR 2 2 1999



99-1430-027 Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene SO SHAN Certificate of Death CHAN 1. Decedent's Name (First, Middle, Last) **Physician** /Medica Examine **Funeral** Director Paper 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0020 . Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examin

3. Time of Death 2. Date of Deeth

MARCH 12, 1999

SO	SHAN	CHAN							MARCH	11.1999	) D	15.	30 PM
4e Fecility Name (	(If not institution, g	ive street and number	)				4b. City, To	wn, or Lo	ocation of Death				JU-FM
HOWARD	COUNTY	GENERAL HO	SPITAL	,			COLUM			HOWA	RD		
5. Sociel Security 1	Number 6.	Sex 7. A	ge (In yrs. lest		If Unde Months	Days	If Under Hours	Min	8. Date of Birt (Month, Da	th v. Yeer)		placa (Stentry)	ete or Foreign
218-27-		TUM ZQIF	52	Yrs.					NOV. 21	, 1946	CHI		
Usual Residenca o	10b. County		10c. City, T	own or Lo	ocation							10d. Insid	le City Limits
	Too. County												Yes 2 XNo
MARYLAND 10e. Street and Nu	Imbar		BALT	LMOKI		p Code				10g. Citizen of	What Cou	ntn/2	
		ENILE				1213				CHINA	***************************************	iniy i	
11. Maritai Stetus	NDALE AV	12. Was Decedent	Ever in IIS	13				inin? (Sn	ecify Yes or No		e - Ameri	can India	n.
	ried 2 Married	Armed Forces	?	10.	If Yes, spe	ecify Cub	an, Mexica	n, Puerto	Rican, etc.)		ck, White,		
3 Widowed 4 Divorced Year or Dates:					1 Yes	2∭ No	Specify:			Specif		INESI	7
	15. Decedent's	Education	1	6e. Dece	dent's Usu	ual Occup	pation			16b. Kind of B			
(Special Elemantary/Second	cify only highest g	rade completed) College (1-4or	5.1)	(Give	kind of w	ork done use ratire	during mos	t of work	ing				
	8	College (1-40)		SEAMS	STRES	S				CLOTHI	NG		
17. Father's Name	17. Father's Name (First, Middle, Last)						18. Moth	er's Nama	a (First, Middle,	Meiden Sumer	ne)		
TAI	CHUN	CHAN					PO		TOM	НО			
19a, Informant's N	lame/Ralationship	(Type, Print)		19b. Maili	ing Addras	s (Street	end Numb	er or Run	al Routa Numb	er, City or Town	, Stete, Zij	p Code)	
THEANY	YIN	(FRIEN					VENUE	S	ILVER S	PRING,	MARY	LAND	20910
20a. Method of Dis		☐Removal from State	cami	e of Dispo etery, cre	osition (Na metory or	ime <i>of</i> othar ple	ca)		Deta	20c. Location	- City or T	own, Stat	le
	5 Other (Spec		CCC 1	LLC				13	3/24/99	STEVENS	VILL	E, MA	ARYLAND
21. Signature of F	uneral Service Lic	ensee					ess of Fecili		OME PA				
12.1	10	5.11.								BURNIE,	MAR	YLANI	D 21061
23a. Part1. Enter	the disease, or co	mplications thet cause ly one cause on each	d the death. I	Do not en	ter the mo	de of dyi	ng, such as	cardiac	or respiretory a	rrest,		Approx	imete I Between
SHOCK, OF HE	art railure. List on	A A		-	-		2						and Deeth
Immediate Ceuse disease or condition	(Finel	N	lutte	06	(re	128	Lit	1/1/8	rund	(			
resulting in death)		θ	Due to (or as	a conse	quence of	):	, 01		30-1-07	3			
											1		
Sequentially list co	onditions,	b	Dua to (or as	s a conse	quence of	):							
Sequentially list co if any, leeding to it cause. Enter Und	erlying										1		
Causa (Diseese or that initiated event resulting in daath)	is	C	Due to (or as	e conse	quence of)	:							
l cooking in outlin,													
		d									1		
Part II. Other signi	ificant conditions	contributing to death	out not resultin	ng in the u	undertying	cause gi	ven in Part	l.	23b. Dld	tobacco uss co	ontribute 1	to the car	use of death?
									10	Yss 2 No	3 Pro	bably	4 Unknown
										-	1		
										en eutopsy ormed?	a	vailable p	psy findings prior to n of cause
											of	f daeth?	I OI Cause
									1/2	Yes 2□No	1	Yes	2 No
25. Was case refe examiner?	erred to medicat							e of Daat	h (Check only	one)			
1 XYes 2		Hospitet: 1 ☐ Inpat	ent 2X ER	/Outpatie	nt 3 🗆 C	MUA		ursing Ho	ome 5 🗆 Resi	dence 6 □Ot	her (Spec	ify)	
27. Mannar of Dea 1 □Netural	th 5 Pending	28a. Date of Inj (Month, D	ay Year) 28	Bb. Time of	of 2	28c. Inju Wo		,	28d. Dascribe	how injury occu	rred	4	
2 Accident	investiget	ha J	99 1	45	O M		Yes 2		2001	ed 8	fel		
3 ☐ Suicide Homicide	6 Could not determine	ZOB. FIAGA OF II	iury - At home	, farm, st	reet, facto	ry, offica		1	28f. Location (	cation (Street end Number or Rurel Routa Number, y or Town, State)			
			Kork	iNg	107				revi	t Court	1700	run	Konsti
29a. Cartifiar (Check only	1☐ Certifying I	Physician: To the best aminer: On the basis of	of axamination	dge, deal and/or in	th occurred	at the ti	ime, dete ar optnion, das	nd plece, ath occur.	and dua to tha red at the tima,	cause(s) and m data and place	anner as , and dua	stated. to tha cau	use(s)
one)	d title of cardific-	end manner s	teled.				ee number			20d Date eign			

To the Hospital or Attending Physician: The law requires that the death certificate be axecu within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the burial-tra Division of Vital Records, P.O. Box 68760,

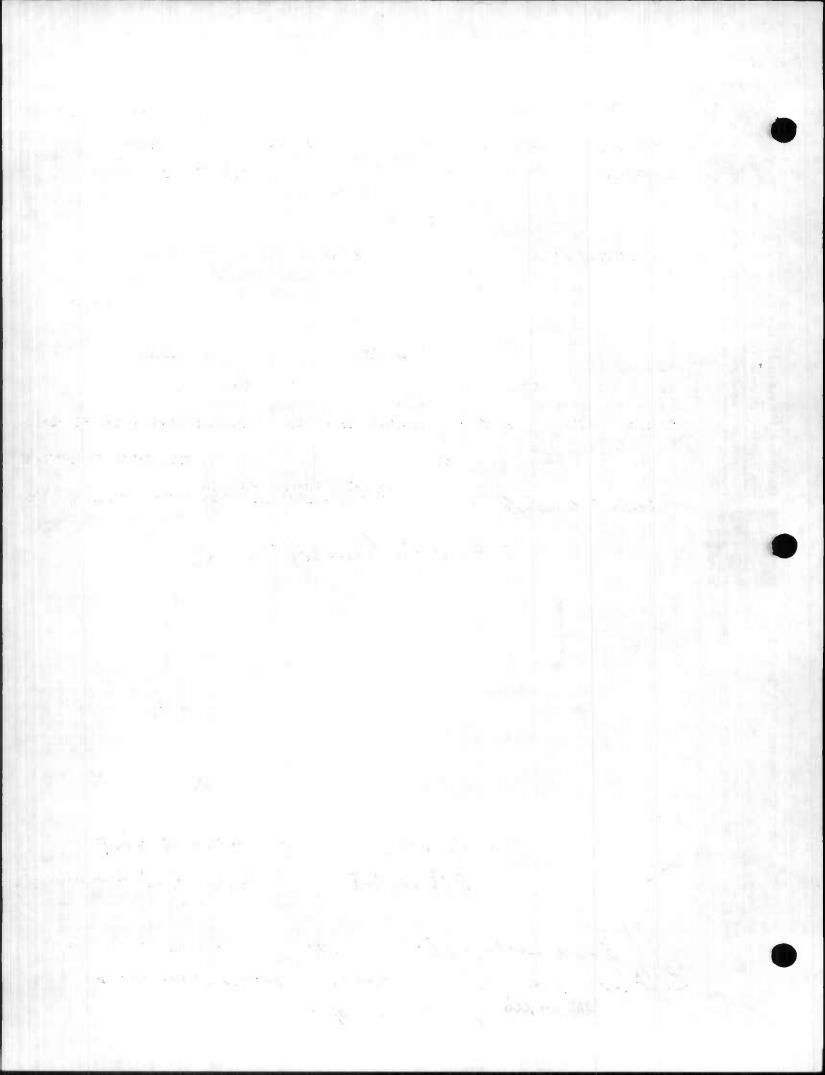
> State Registrar

32. Registra's Signature

111 Penn Street, Baltimore, Maryland 21201

(Itam 23e) (Type, Print)

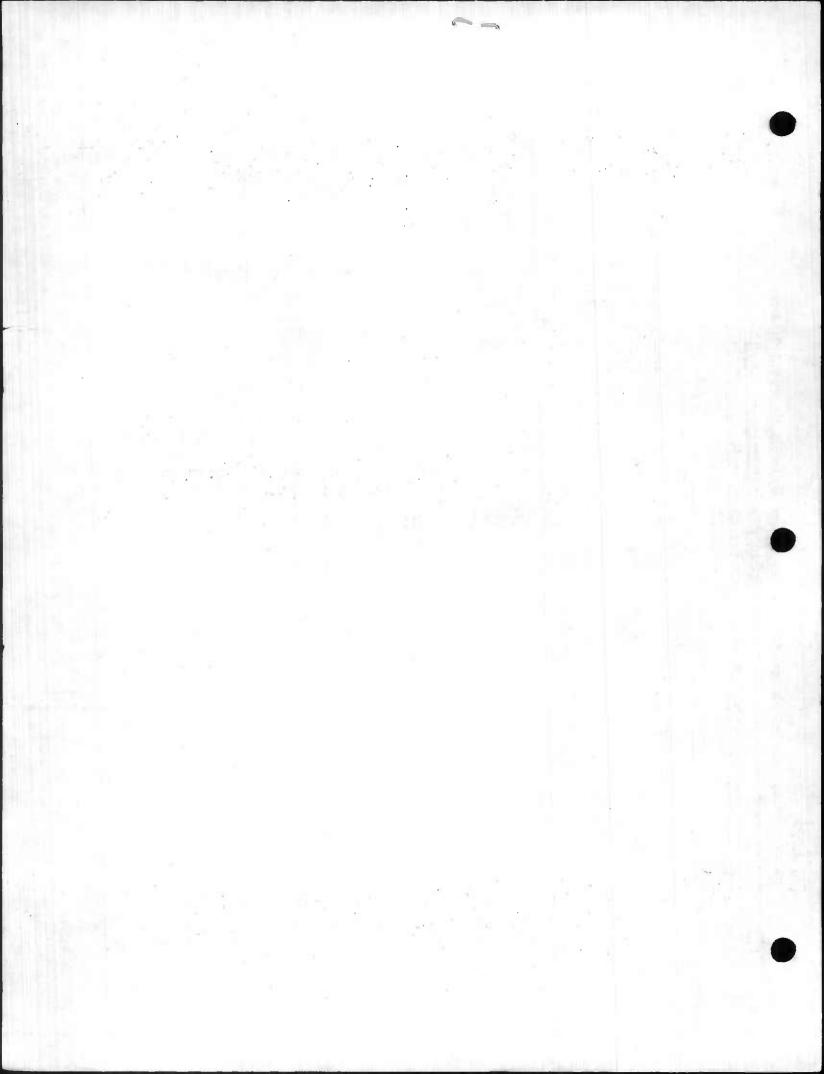
OCME



	1.5						Cert	tificate	e of L	Death	1	Reg.	No. 9	U	7011	
ician			e (First, Middle, I								2. Date of Month	1	Day	Year	3. Time of Death	
lical			D COATES		and number)			_	4	b. City, Town, o		16-99 Death	4c. County	of Death	10:50 P.M	
ner			ICHEY HO							BALTIMO				0.000		
	5. Social Se	rows	n	5. Sex 1[XM 2		6 (In yrs.	last birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 24 H	n. (Monti	f Birth n, Day, Yea -36	ar)	9. Birthp Cour PA	place (State or Foreign ntry)	
	Usual Resid	JENICE OF	10b. County			10c. Cit	y, Town or Loc	ation			-			1	0d. Inside City Limits	
ctor	MD.						BALTIM	IORE	RE						XXYes 2□No	
Director	10e. Street	and Nun	nber					10f. Zip 0	Code 10g. Citizen of What Country						ntry?	
Funeral	1826	1826 WALBROOK AVE.  11. Marital Status  12. Was Decedent Ever in U.S.					S. 13. W	21217  13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						lo- 14. Race - American Indian,		
	1 Never Married 2 Married 1				med Forces?  Yes 2 A		lf.	Yes, specif	ify Cuba	Specify:	erto Rican, etc	.)	Blac	ck, White,	etc.	
d by		Ye	es, Give ar or Detes:								Specify: BLACK					
Completed		Education grade comp	life. DO NOT use retired)					ition lu <i>ring most of w</i> )	orking	16b.	. Kind of B	usiness/In	dustry			
mo	Elementa	ry/Secor	ndary (0-12)	Co	illege (1-4or 5	i+)		VING				М	OVING	3		
Be C	17. Father's Name (First, Middle, Last)								18. Mother's N	ame (First, Mi						
10	LEV	LEVERN J. BRYAN  19a. Informant's Name/Relationship (Type, Print)  19b. Meiling Address (Si								IZETTA				0 70		
			BRYAN	p ( <i>Type, P</i> n	int)		1826			and Number or a	ALTIMOI		RYLAN			
	20a. Method	d of Disp	osition			20b. P	tace of Dispos	ition (Name	e of		Date	1	Location -			
		1 ⊠ Buriel 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  MT. ZIO!									3-22-9	99 BA	LTIMO	RE MI	D.	
	21. Signatu	ra of Fur	neral Service Lic	censee	02	1				s of Facility E					L HOME P.A	
н	Immediate disease or d	Cause (I	Final	omplication one cause a	shat caused se on each lin	of the death	n. Do not enter	r the mode	of dying	De Co	ec or respiret	ory errest,	ease	1	Approximate Interval Between Onset and Death	
il Examiner	Immediate disease or resulting in Sequentials if any, leadic cause. Enter	Cause (I condition death) y list con ing to im er Under	Final nditions, mediate thing	a	deg	OIVE Due to (o	n. Do not enter	r the mode	of dying	g, such es card	ec or respiret	ory errest,	lose	2	Approximate Interval Between Onset and Death	
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DHMH 16 Rev 6/95

ORIGINAL



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

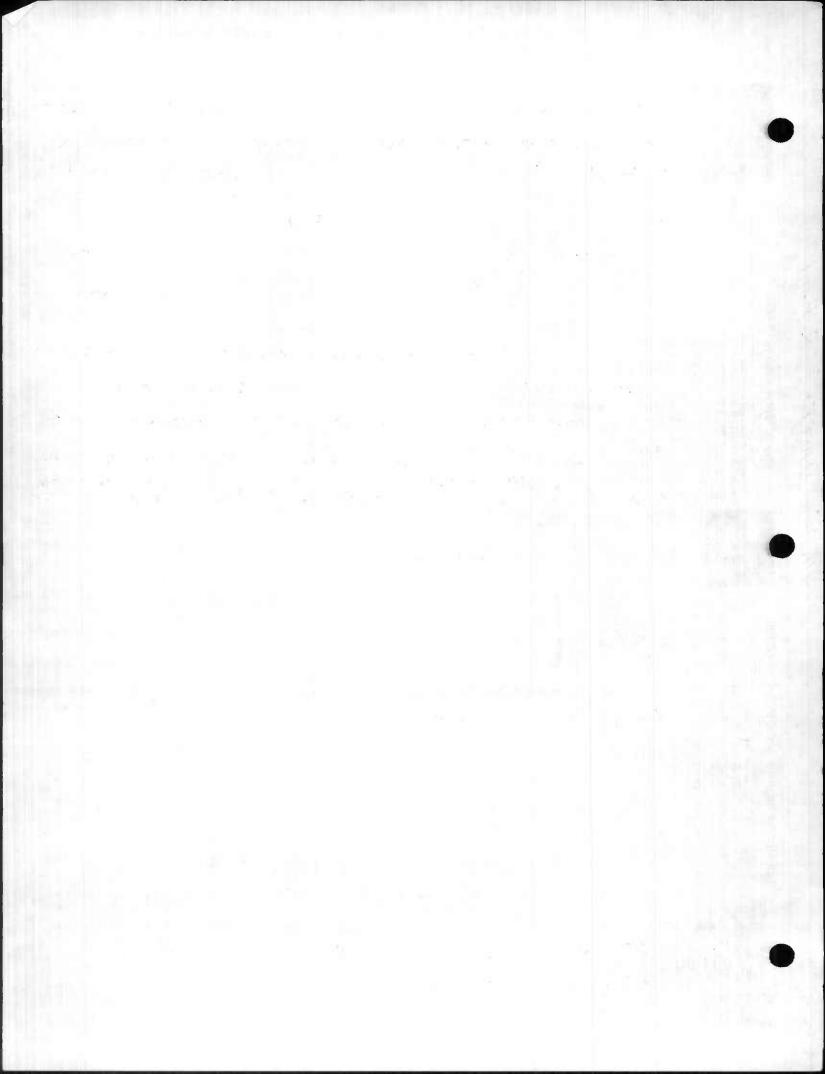
			State of Maryland / D	Department of F Certificate of the control of the c		ntal Hygien	110.	8106		
D	hysician	Decedent's Name (First, Middle, Last)			2		ay Yaar	3. Tima of Death		
	/Medical	Robert J. Casp					18, 1999	2:50PM		
E	xaminer	4a Facility Nama (If not institution, give str			1b. City, Town, or Loca		lc. County of Death			
		GREATER BALTIMOS  5. Social Security Number 6. Sex	RE MEDICAL CE  7. Age (In yrs. last birt		TOWSON If Under 24 Hrs. 8	Data of Birth (Month, Day, Yea	BALTIMOF	( E: place (State or Foreign ntry)		
	neral ector		-De	rs. Months Days	Hours Min.	(Month, Day, Yea 09-03-193	-03-1939   Country) Mary 1			
		Usual Residence of Decedent						,		
arylar .	T T	10a. State 10b. County	10c. City, Towr					10d. Inside City Limits  1 X Yes 2 □ No		
e A	or 28a-1 be notified Director	Maryland N/A			timore	40- (	10g. Citizen of What Country?			
death with the Maryland	23e or 28e-t ehow	10e. Street and Number 5004 Oaklyn Av	enue	10f. Zip Code	21206	109. 6	United States			
So sefter	or, or flows	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedant Ever In U,S. Amed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates;	13. Was Dacedant of H if Yes, specify Cubs 1 Yes 2 No	lispanic Origin? (Speci an, Mexican, Puarlo Ric Specify:	fy Yes or No- can, atc.)	No- 14. Race - American indian, Black, Whita, etc.  Specify: White			
5-0 72 ho	naturel, adical Ex-	15. Decedant's Educat (Specify only highest grade of		Decedent's Usual Occup (Giva kind of work done	during most of working		Kind of Business/li	ndustry		
within ene.		Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	1)		Maryland Govern			
	S F O	17. Father's Name (First, Middle, Last)	4 Yrs.	Classificati	on Special  18. Mother's Name (			Government		
ylan ould be f	Be ed of	Eugene F. Casper				atherine				
E 4 5	martic To	19a. informant's Name/Relationship (Type		Mailing Address (Street	,			p Code)		
C/ 0/2	r trau	Richard J. Martin /		527 Brightw	ood Road	Millers	ville, MD	21108		
ore, M	othe	20a. Method of Disposition	cometer	Disposition (Neme of	ce)	Date 20c.	Location - City or T	own, State		
Peges nent of 1	inty or	1 🕅 Burial 2 ☐ Cremation 3 ☐ Ran 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	wood Cemete	- 1	3/22/99 Baltimore, Maryland				
Baltimore,	important: if item 27 is marked other than eny injury or other traumatic event, the M DACE.  To Be Comp	21. Signature of Funeral Service Licensee	Michael E. Canapp	or J. RUCK, INC. 5305 Harford Road Baltimore, MD 21214						
		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. Do r	not enter the mode of dyir	ng, such as cardiac or i			Approximate interval Between		
(0)	dical niner	immadiata Causa (Final disease or condition resulting in death) a.	Premone Due to (or as a c	consequenca of):				Onset and Death		
Box 68760, death certificate be executed	physician and stress the burial-transit	b b								
Box 6		d								
O. E	ne et ned fo	Part II. Other significant conditions contri	outing to death but not rasulting in	an in Part I.	art I. 23b. Did tobacco use contribute to the cause of death?					
S, P.O	e detect	Longstre has	it forling			1 Ves	200 3□ Pr	obably 4 Unknown		
Records,	ate has been signed by the efferding page 2 should be deteched for use a Completed by Physician/M					24a. Was an au performed	0	Vere autopsy findings vailable prior to ompletion of cause f death?		
	page 2					1 ☐ Yes	2 DANO 1	□Yes 250No		
/ita	Be	25. Was case referred to medical examiner?			26. Place of Death (	Check only one)				
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On C	led in by the funeral Certification:	27. Manner of Death 1 Natural 5 □ Pending		ime of 28c. Injury Woo	yat k? Yes 2 □ No	d. Describe how in	jury occurred			
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Division of To the Hospital or Attending Phys within 24 hours effect of the Control of the Contr	pletely fille	29a. Certifier Check only one) Certifying Physic Check only one)	an: To the best of my knowledge : On the basis of examination and and manner stated.	, death occurred at the tir d/or investigation, in my o	ne, date and place, an plnion, death occurred	d due to the cause at the time, date a	o(s) and manner as and placa, and due	stated. to the cause(s)		
To the within 2	Me Me	29b. Signature and title of certifier		29c. Licens	e number	29d. I	Data signed (Month	, Day, Year)		
		I muna &	to m	03	2544	3	110190	1		
:NIX	15)	30. Name and address of person who comp			- 13		1 13 11			
NIX		6701 N.C	Laules St	Bult .	w-e, M	0 211	-0-1			
R	State legistrar	31. Date filed (Month, Day, Year) MAR 2 2 19	32. Registrar's Signature	p. Spor	Las .					

DHMH 16 Rev 6/95

Robert

CASPER,

NAME:



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day March 18, 1999 4:30 A.M. Lillian Chambers Beatrice 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Baltimore Gilcrest Center Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 1 F Yrs. 94 214-30-6926 June 19, 1904 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Baldwin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13830 Manor Glen 21013 Road U.S.A. 14. Raca - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 5 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Canada School Teacher 12 -0-School Teacher 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Valmore Lemire Winnfred Boisvert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Helen Caldwell (daughter) 13830 Manor Glen Road, Baldwin, MD 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - Cify or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/22/99 Clarksville, MD St Louis R.C. Ch. Cem. 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Loring Byers Funeral Directors, Inc. ensins 8728 Liberty Road Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Final end-stra cardiom disease or condition resulting in death) Artery disens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide tX Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2☐ Medical Examiner: On the basts of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier

physician end s the burial-trensit law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, signed by the should irector, page 2 The Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice itely filled in by the funeral director, it To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b

**Physician** 

/Medical

Examiner

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Funeral

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**Funeral** 

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7 is marked other than "natural", or items 23s or traumatic event, the Modical Examiner must be

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Department of Important: If it any Injury or o

**Physician** /Medical

Examiner

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Certification: To

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29c. License number

29d. Date signed (Month, Dey, Year) March 18, 1999

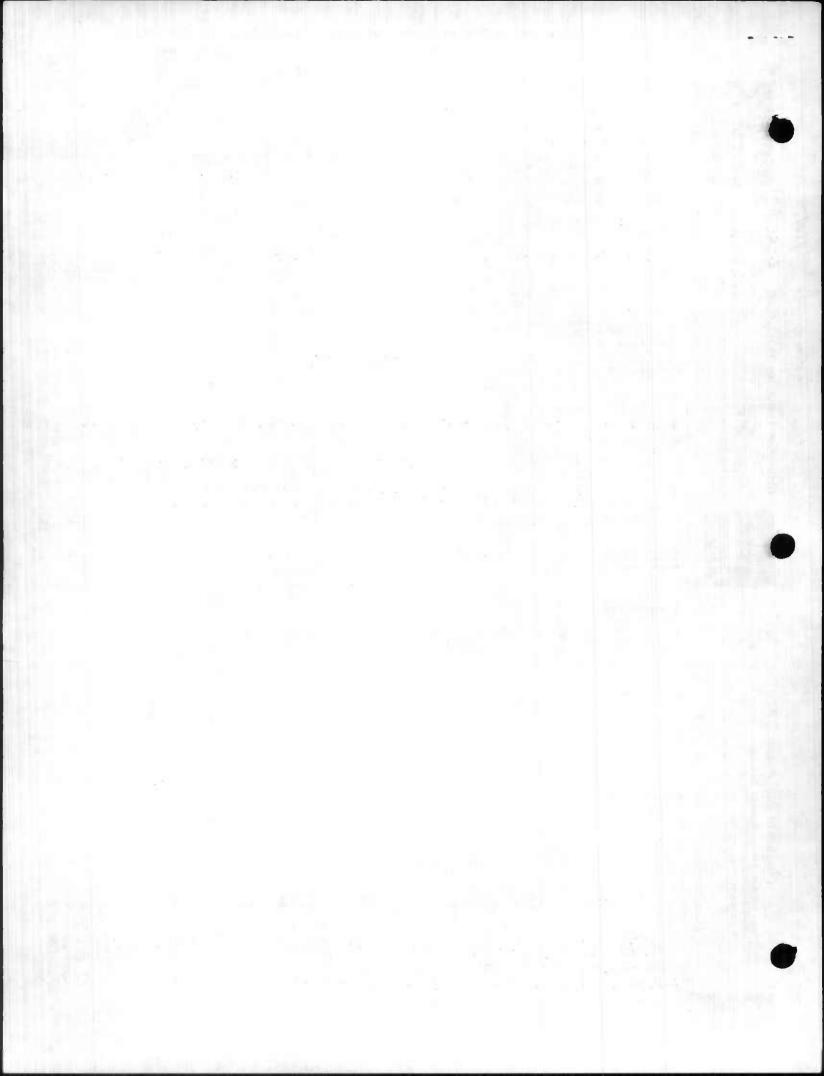
completed cause of deeth (Item 23e) (Type, Print) N. Charles St. Bolto, and 2120x 6701 100 G-BW

31. Date filed (Month. Day.

29b. Signature and title of certify

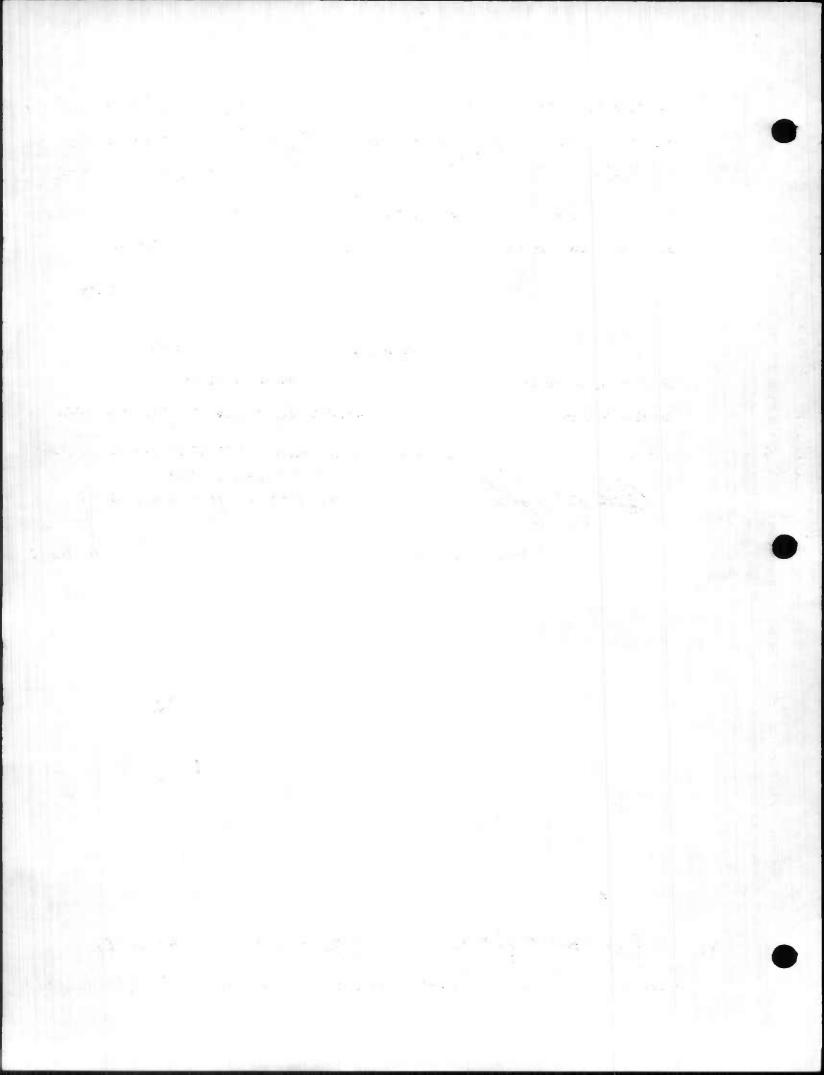
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edical	-	William H. Dav		)			4b. City, Town, or Lo	MARCH cation of Deeth	4c. County		135 P.M	
miner eral tor	5.	RANKIIN Seu Sociel Security Number 2 217-01-0724	ARE HOSE	piT4/ ge (in yrs. las	Cen I st birthdey) If Yrs.		Roseda If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, De 02/26/	BATT V. Year)	9. Birthpleca (Country) Maryla	Stete or Foreig	
ž		Usuel Residence of Decadent  10e. Stete 10b. County 10c. City, Town or Location								10d, in:	side City Limits	
other traumatic event, the Medical Examiner must be notified at		MD N/A Baltimore							1 A Yes 2 N			
	10e. Street end Number 4206 Springwood Avenue 10f. Zip Code 21206								10g. Citizen of V U . S	What Country?		
	11	11. Meritel Stetus  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorcad  12. Wes Decedent Armed Forces  1 ☑ Yes 2 □ If Yes, Give				Decedent of Hes, specify Cub	lispenic Origin? (Spe en, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	14. Rec Blee Specify	e-American Inc ck, White, etc. White	lien,	
		15. Decedent's (Specify only highest Elementery/Secondery (0-12)	5+)	16e. Decedent (Give kind life. DO	f of work done NOT use retire	petion during most of worki d)	ng	16b. Kind of B	e Shop			
000	17	7. Father's Name (First, Middle, La	ist)		necha	IIIC	18. Mother's Name	(First, Middle,				
To Be		William H. Davi					Margar	et Wink	cler			
		9a. Informent's Name/Relationship Carolyn McCammo			19b. Meiling A	ddress (Street Sherada	end Number or Rura le Dr. Ki	ngsvill	er, City or Town, Le, Mary	Stete, Zip Code land 21	087	
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State of Maryland / Department of Health and Mental Hygiene

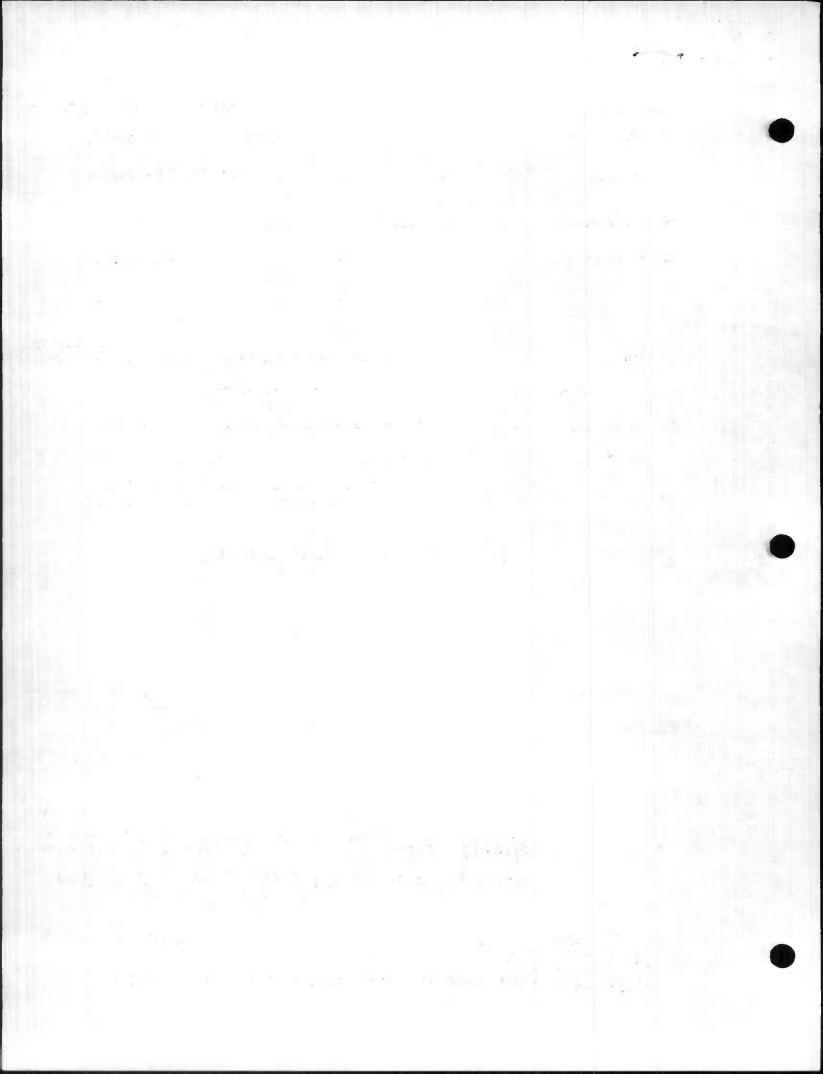
LARUE FLORA DAVIS Certificate of Death 2. Date of Deeth 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician MARCH 18, 1999 LaRue R. Davis 0525 AM · /Medical 4a Facility Name (If not institution, give street end number)
ROUTE#75 & 144 4c. County of Death 4b. City, Town, or Location of Death Examiner NEW MARKET FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Months Days Hours 10 M 20 F Yrs 52 Nov. 16, 1946 Maryland Director 216-44-0250 Usuai Residenca of Decedent with the Meryland 10a, Stete 10b. County 10c. City, Town or Location 10d, inside City Limits r than "natural", or Itema 23a or 28a-1 show the Medical Examiner must be notified at 1 ☐ Yes 2€ No Directo Maryland Frederick New Market 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 6603 Edgewood Rd. United States 21774 Funeral permit. Peges 1 and 2 should be filed within 72 hours efter dee Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 2 any Injury or other traumment of the Page. 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritei Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuef Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) of Health 12th Administration Technician National Institute 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Robert C. Jenkins, Sr. Elva M. Boore 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, Cify or Town, Stete, Zip Code) 19515 Frederick Rd. CaRole J. Lamb (Sister) Germantown, MD 20876 20b. Placa of Disposition (Neme of cametery, cremetory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 3/22/99 Hampstead, MD 22. Name and Address of Fecility Burrier-Queen Funeral Directors, P.A. 21. Signeture of Furtural Envice Lice 1212 W. Old Liberty Rd. Winfield, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heer feilure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** tmmediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner ettending physician end for use es the bunel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or as a consequenca of) 98 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yee 2 ☑ No 3 ☐ Probably 4 ☐ Unknown by Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificete hes 1 PYes 2 No 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence MXOther (Specify) ROADWAY 2 ₩XYes 2 No 286. Dete of Injury
(Month. Dey Year)

286. Time of Injury S. I.S. Injury S. 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28d. Describe how injury occurred
Driver of motor vehicle 27. Manner of Death 28c. Injury at Work? Certification: of or Attending Father death. After 5 Pending 1 Natural 1 Yes 2 No collides with another vehicle
281. Location (Street and Number or Rural Route Number,
City or Toym, State) investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide Frederick Co, Md 2 RT 75 24 hours e Funeral D 29a. Certifier t 🗆 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the cause(s) and manner as steted. Medical completely Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner steted. (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier O.C.M.E MARCH 18, 1999 tane

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

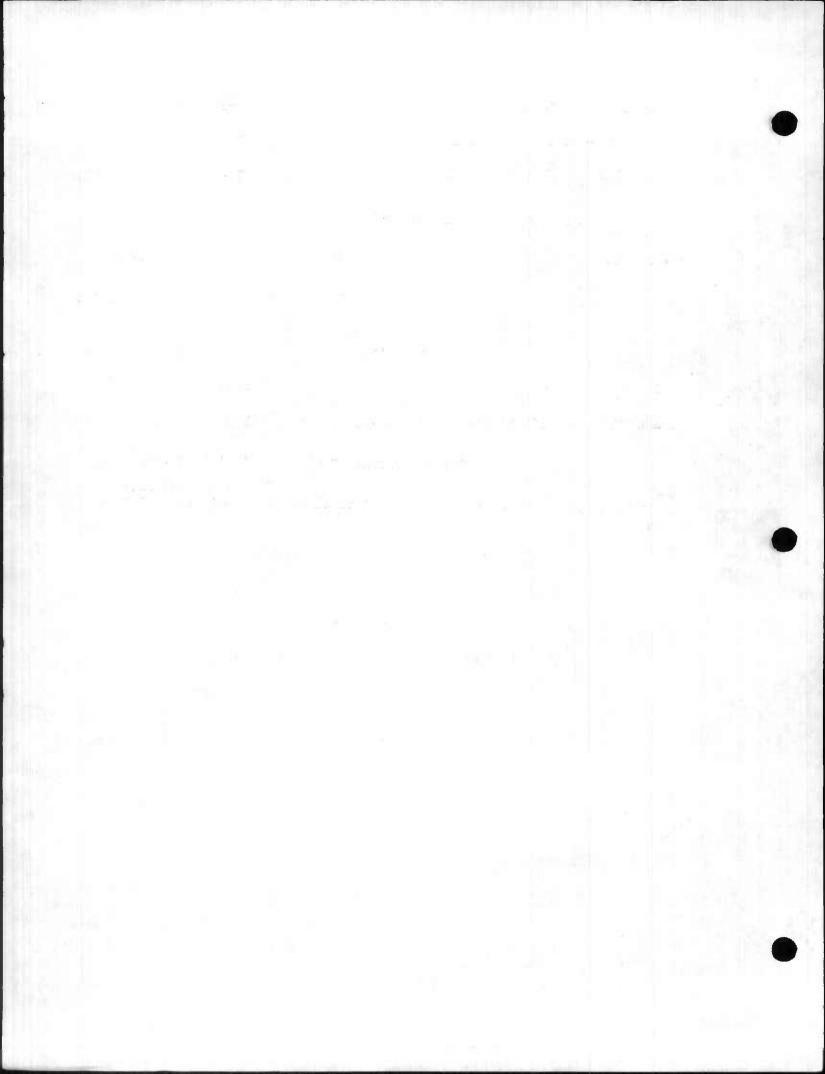
Toscon Pestonec 111 Penn estance 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Dey, Year) 32. Registrar's Signature

MAR 2 2 1999



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Registrar



State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Anthony
4a Facility Name (If not institution, give street and number) Drumgoole 18 1999 13:30 March /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Yaar | If Undar 24 Hrs 5. Social Security Number 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 1₩ 2□ F 218-62-9984 43 Yrs. Director Nov. 23, 1955 Usual Residence of Decedent 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits r than "natural", or harms 23s or 28s-f ahov the Medical Examiner must be notified at n/a Md. Baltimore 1 Xes 2 No Director 10e. Street and Number 10f Zin Code 10g. Citizan of What Country? 21207 2005 Forest Heights Drive USA deeth Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. filed within 72 hours efter 1 Never Msrried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: Baltimore, Maryland 21215-0020 1 Yas 2√No Specify: Specify: Black p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Bureau of Rec. & Parks I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Baltimore City 11th Grade permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If flem 27 is marked other any injury or other treumstic evant appa. 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Susie V. Gross Melvin John Drumgoole 19a. Informant's Name/Ralationship (Type, Print) Wife L. Rene' Drumgoole 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2005 Forest Heights Dr. Baltimore, Md. 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition to Burial 2 Cremation 3 Removal from State March 22 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 22. Nama and Addrass of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Count 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Do not enter the mode of dying, such as cardiec or respiratory arrest, 23a. Part 1. Enter the disease, or complications that cause of shock, or heart feilure. List only one cause on each fine Approximate Interval Between Onset and Death Physician Immediata Cause (Final disease or condition resulting in death) /Medical 72 hours +ungal Examiner Examiner 5 days Sepsis physician and the buriel-trensit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of Box 68760 Physician/Medical Dua to (or as a consequence of): 180 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Dilated cardiomyopathy, acquired immune Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed deficiency syndome, and stage rend disease diabetes mellitus small sowel osstruction 1 ☐ Yes 2 KNo Division of Vital or Attending Physician: 25. Was casa refarred to medical examiner? Be 26. Placa of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1□ Yas 20 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: Affer 5 Pending invastigation 1 (Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 2 Accident 6 ☐ Could not be detarmined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) Medical 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certified Willel Doctor RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe Street, Bultimor, Matthias W. Et mann Mark

**DHMH 16 Rev 6/95** 

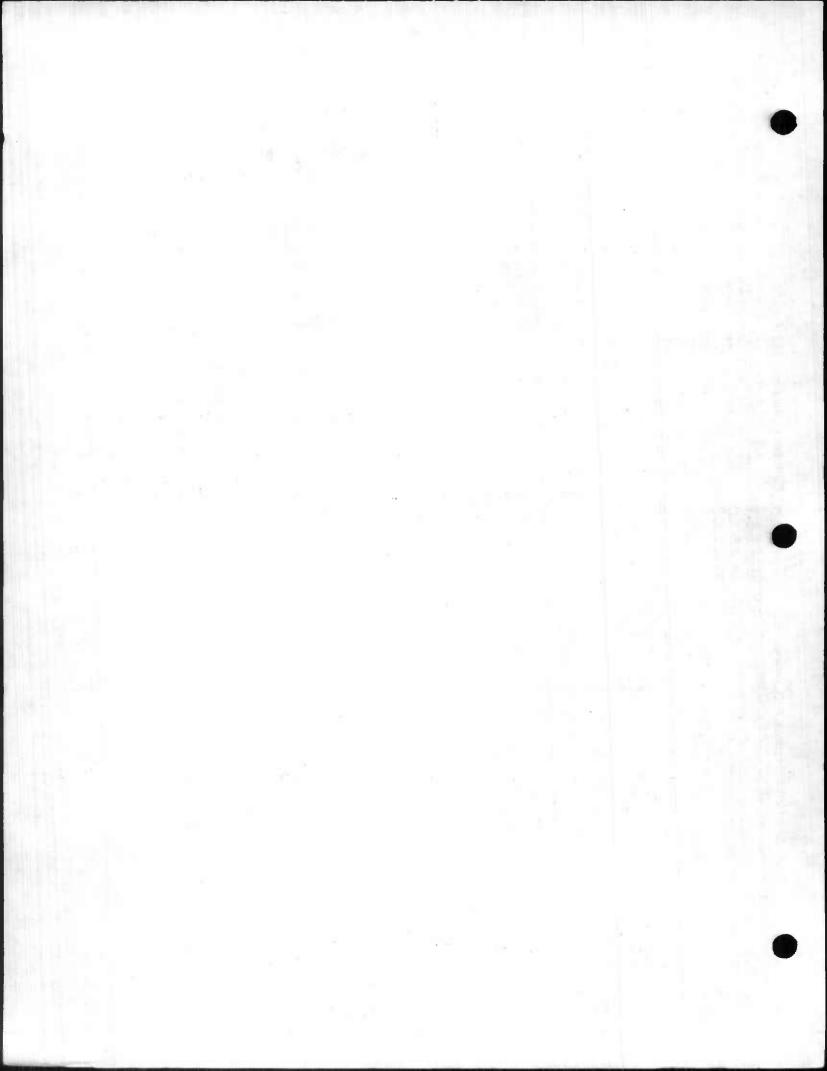
State

Registrar

31. Data filed (Month, Day, Year)

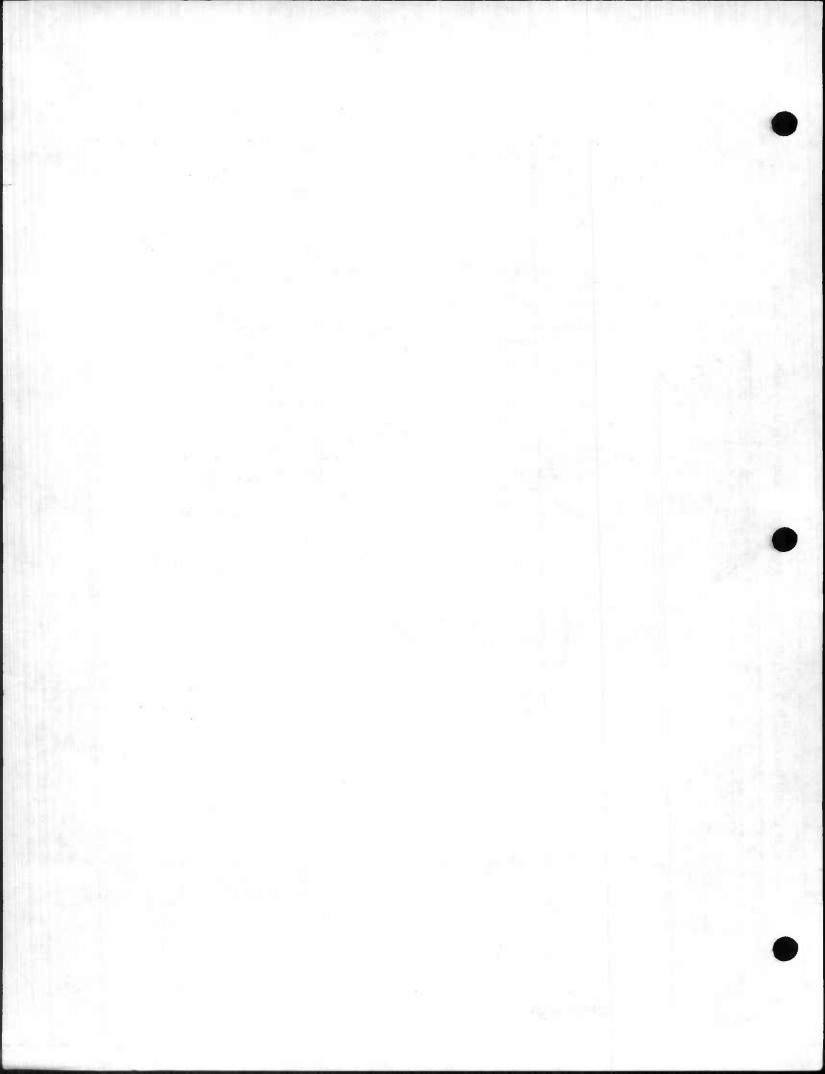
MAR 2 2 1999

32. Begistrer's Signature

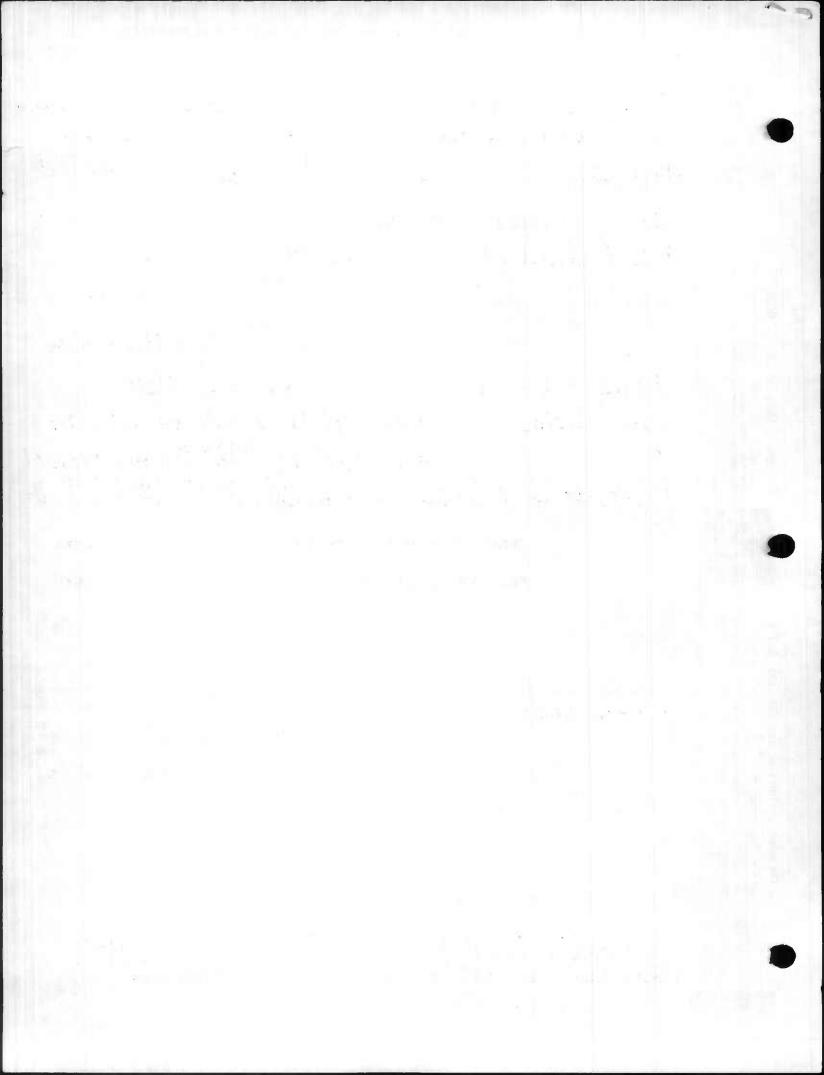


State of Maryland / Department of Health and Mental Hygiene

	Decedent'e Name (First, Middle, La.	st)	C	Certificate of	Death	Re 2. Dete of Death	g. No.	3.	Time of Death		
Physician		н.		DUCKW	ORTH	Month	Day	Year	:30 PM		
/Medical Examiner	4a Facility Name (If not institution, give		-1//	2001111	4b. City, Town, or	MARCH 18 Location of Death	4c. County of	of Death			
Examiner	211 WILLIAMS ROAD				FERNDA	LE	ANNE A	RUNDEL			
Funeral Director	5. Social Security Number 6. S		In yrs. last birtho	Months   Day	r If Under 24 Hrs.	8. Date of Birth (Month, Day, APRIL 3	Year)		(Stata or Foreign		
and and	10a. State 10b. County	1	Oc. City, Town o	r Location				10d. In	side City Limits		
Mary He ah	MARYLAND ANNE ARUNDEL FERNDALE  106. Street and Number 107. Zip Code							1	☐ Yes 2 No		
h with the Mar 23a or 28a-fai at be nottled		10	og. Citizen of W U.S.								
5-0020 72 hours after death with the Manyland natural; or Items 23a or 28a-f ahow size. Examiner must be notified at sted by Funeral Director.	3 □ Widowed 4 □ Divorced	12. Wes Decedent Ev Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1951-	I3. Wes Decedent of If Yes, specify Cu 1 ☐ Yes	Hispanic Origin? (S ban, Mexican, Puart Specify:	pecify Yes or No- o Rican, etc.)		- American Inc k, White, etc.			
121 Men	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+)	(G	a. Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired)  ENGINEER		king	AIRPLAN	1E	E		
				MOINDER	18. Mother's Ner	ne (First, Middle, M	MANUFAC laiden Sumame				
Maryiand d2 should be file h and Mental Hy 7 le marked oths traumatic event		DUCE	KWORTH		MARGARE	T	FF	RAME			
2 should and Mer and M	19a. Informant's Name/Relationship (	Type, Print)	19b. N	ailing Address (Stre	et and Number or Ru	ıral Route Number,	City or Town,	State, Zip Code	9)		
_ C = N =	KAREN J. DUCKWORT	H (WIFE)			ROAD, FE	RNDALE, M	IARYLANI	21061			
Baitimore, Semit. Pages 1 an Separtment of Heal moortant: if Item 2 my Injury or other mos.	20a. Mathod of Disposition  1 🖾 Burial 2 🗀 Cremetion 3 🖂  4 🗀 Donation 5 🗀 Other (Specify		cemetery,	sposition (Name of crematory or other points)  N CEMETER		Dete 2 3/22/99 B	Oc. Location - 0				
Baitim pemit. Pag Department Important: P eny Injury o	21. Signature of Furnital Service Licen	Day A		22. Name and Add	ress of Fecility SII	GLETON F	UNERAL	HOME, I	P.A.,		
X 68760, entiticate be executed ling physician and is as the burial-transit Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	o. Pher	Je to for as a cor LMD M Cu Je to for as a cor LLMS (so LLMS (so Je to for as a con	sequence of):	Sclere	) \$1 5		2	weeks 5 years		
the death cert by the attendin sched for use hysiclan/N											
U 5 25 U	Part II. Other significant conditions of	entributing to death but i	not resulting in th	e underlying causa (	given in Part I.	23b. Did tol		tribute to the	cause of death?		
cords, vequires should be should be						24a. Was an		eveilable	utopsy tindings e prior to lion of cause 17		
Vital Rel						1□ Ye	s 200 No	1 ☐ Yes	210 No		
f Vita yelclen: s certific director.	25. Was case refarred to medical	Manadah		10	THE RESERVE TO THE PARTY OF THE	oth (Check only one	1)				
Division of Vita To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.  Medical Certification: To Be (	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 \( \rightarrow \) Accident investigation	28a. Data of Injury (Month, Day Y						me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
Division of the control of the contr	3 Suicide 6 Could not be determined							and Number or Rural Routa Number, ate)			
Di he Hospitat or in 24 hours afti he Funeral Dir pletely filled in edical Ceri	29a. Certifier (Check only one) 18 Certifying Phyone 1 Medical Example 1	reiclan: To the best of n iner: On the basis of ex and menner state	camination and/o	eath occurred at the r investigation, in my	tima, data and place opinion, death occu	, and due to tha ca irred et the time, da	use(s) and mer ita end place, a	nner as stated. and dua to the o	ceuse(s)		
To the within 2 To the comple	29b. Signature and title of bertifier	1.0		29c. Lice	nse number	29	d. Date signed	(Month, Day,	Year)		
	Year 7 Hay	me M.D		Di	52728		3/19/9	99			
MIG.	30. Name and address of person who	completed cause of deal	th (Item 23a) (Ty	pe, Print)	1. 0.	1	11 1				
HH (EO)	John F. Loome.	M. D. 145	+ Balklo	re 3 Anno	yds Blvd	mon	W, MI	210	12		
State Registrar	1000	99	Las L	1. Anne	11						



			State of Mary		artment of F rtificate of		nental Hygie	22	0 9	9025
		1. Decedent's Name (First, Middle, Last)	0 !				2. Dete of Death Month	Day	Yeer	3. Time of Death
Physic /Medi		WORLS K.	Edwards				MARCH	18, 1		11:05P.M
Exami		4a Fecility Name (If not institution, give Saint Joseph M		enter		4b. City, Town, or L		4c. County o		more
Funeral Director		214-10-05-101	7. Age (In	yrs. last birthday)	If Under 1 Year Months Deys		8. Dete of Birth (Month, Dey. Y	1920	9. Birthp Goun Ma	lace (State or Foreign try) LYI and
Maryland H ahow	tor	Usual Residence of Decedent  10a. State  10b. County  RG HI	10	c. City, Town or La	cation				10	0d. Inside City Limits 1 ☐ Yes 2 No
Mith the	ai Director	10e. Street and Number	d Pd	TV-A-VI	10f. Zip Code	234	100	. Citizen of W	hat Coun	try?
72 hours effer death with the Maryland natural; or items 23a or 28s-f show deal Examiner must be notified at	by Funeral	11. Maritel Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub	Hispenic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		, White,	an Indien, etc.
d within piena. r than	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of world)	king	b. Kind of But	Li	ghting
of and by	To Be	17. Father's Name (First, Middle, Last)  ARYUR F. K	Rause			Katt	e (First, Middle, Ma	Gali	6	
s f and 2 should f Health end Mer Nem 27 la marks other traumatic		19a. Informant's Name/Relationship (Ty Sandla ARKU)	13	19b. Mailin	Edgef	ield Rd.	Baltin	Old County of Town, S	ld a	21234
Pages nent of ant: If Its ury or o		20a. Method of Disposition  1 ⊠Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	Parkux	netory or other ple	etery!	Valch 22 P	ackvij	Le 1	Vacyland
permit. Pa Departmen Important: any Injury		23a. Fant. Enlar the disease, or compliance, or heart failure. List only or	I. Wel	18 8	R OB A er the mode of dyi	tackord	CANS FU Rd. B or respiratory arres	refel	SEP_	10.000 Maria James 1 Approximate Interval Between Onset and Death
Physician /Medicai Examiner		Immediate Cause (Final disease or condition resulting in death)	GRAM NEG	ATIVE E		MIA				DAYS
nted Insit	Examiner		PERINEPH	HRIC ABS	SCESS				-	DAYS
icate be asscuted physician and s the buriel-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	i	to (or as a consec					1	
daath certificate be axecuted e attending physician and ed for usa as the buriel-transit	n/Medio	resulting In death) Last	Due	to (or as e conseq	uence of):					
that tha	by Physician/Medical	Part II. Other significant conditions con		ot resulting in the u	nderlying cause gi	ven in Part I.	23b. Did tob			the cause of death?
aw requisite been 2 should	Completed to						24a. Was an performe	autopsy ed?	av	ere autopsy findings allable prior to mpletion of cause death?
The ata h	Com						1 ☐ Yes	<b>X</b> □ No	10	Yes 2☐No
Physicien: The this certificate ral director, per	Be	25. Was case referred to medical examiner?	lospital: 🔀		0	28. Place of Dea	th (Check only one)			
Phys this ral di	- To	1 ☐ Yes 2 ⚠ No P	ospital: Inpatient 28a. Date of Injury	2 ER/Outpatier	II 3LI DOA	4 LI Nursing H	ome 5 Residen			γ)
f or Attending I after death. Director: After In by the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Sulcide 6 Could not be	(Month, Dey Ye	nar) Injury	M 1	Yes 2 No	28f. Location (Stre	et end Numbe		I Route Number,
To the Hospital or Atlanding I within 24 hours after death. To the Funeral Director: After completaly filled in by the funer		29a. Certifier 1 Certifying Phys	building, etc. (S	pecify) y knowledge, deatl	n occurred at the ti	ime, date and place	City or Town,	se(s) and ma	nner as s	lated.
the Hoshin 24 h the Fur Theletaly	edicai	(Check only 2 Medical Examination)	ner: On the basis of exa and manner stated.	mination and/or in	vestigation, In my	opinion, death occur	rred at the time, date	and place, a	and due to	the cause(s)
To the within To the comple	M	29b. Signeture end title of certifier	You M.	0.	29c. Licen D 24	se number Ø34	290	I. Date signed	(Month,	Dey, Year)
1(10)		30. Name and address of person who co	mpleted cause of death D., 7601			OWSON, N	MARYLAND	2120	4	
Sta	ite	31. Date filed (Month, Day, Year) MAR 2 2 1	32. Registrar's	Signature	1. Inc	1				



# Taison, Margaret

1. Decedent's Name (First, Middle, Last)

MARGARET

GENESIS

MARYLAND

11. Maritei Status

10e. Street end Number

1 Never Married 2 Married

10a. Stete

Directo

Funeral

5. Social Security Number

212-22-4070 Usual Residence of Decedent

4a Fecility Neme (If not institution, give street and number)

10b. County

N/A

1200 DRUID HILL AVENUE

Eldercare

1 M 2 X

FAISON

12. Was Decedent Ever in U.S. Armed Forces?

**Physician** 

/Medical

Examiner

**Funeral** 

Director

the Maryland

item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: BLACK þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Is marked other than Elementery/Secondary (0-12) College (1-4or 5+) BALTIMORE LUGGAGE 12yrs FACTORY WORKER 2yrs 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) LEVI BALDWIN LOUISE BEATHEA 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 Vernon Dobson/Friend Department of Health Important: If Itam 27 1219 DRUID HILL AVENUE, BALTIMORE MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition any injury or conce. 1 ☐ Buriel 2XI Cremation 3 ☐ Removei from State METRO CREMATORY 3-23-99BALTIMORE MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE 23a. Pert 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical neumonia Examiner Due to (or es e consequence of) Examiner certificata be axecuted ician and bunal-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequence of): Box 68760, attending physician Physician/Medical the t Due to (or es e consequence of): 50 esn Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. mellitus 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 3 Division of Vital Records, p 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Demento has page 2 2 No certificata 25. Wes cese referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Wursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Dete of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: or Attending 1 Natural 5 Pending ie Hospital or Attending n 24 hours aftar death. ne Funeral Director: Afte 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and piace, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medicai 29a. Certifier (Check only one) To the P within 2 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifler March 20, 1999 127541 10emon Keyer MD 30. Name end address of person who completed cause of death (Item 230) (Type, Pript)

A FETH A RAJA 4367 However Ferry Rd Back-MD 21227

32. Registrar's Signeture Singel.

Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Bith (Month, Dey, Year)

BALTIMORE CITY

21217

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10f. Zip Code

Days

Caton manox

79 Yrs.

10c. City, Town or Location

2. Date of Deeth

Month

4c. County of Death

10g. Citizen of What Country?

U.S.A.

4b. City, Town, or Location of Deeth

Baltimorecity

3. Time of Deeth

Birthplece (State or Foreign Country)

10d. Inside City Limits

Approximete Interval Between Onset end Deeth

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26 1919 NORTHCAROLINA

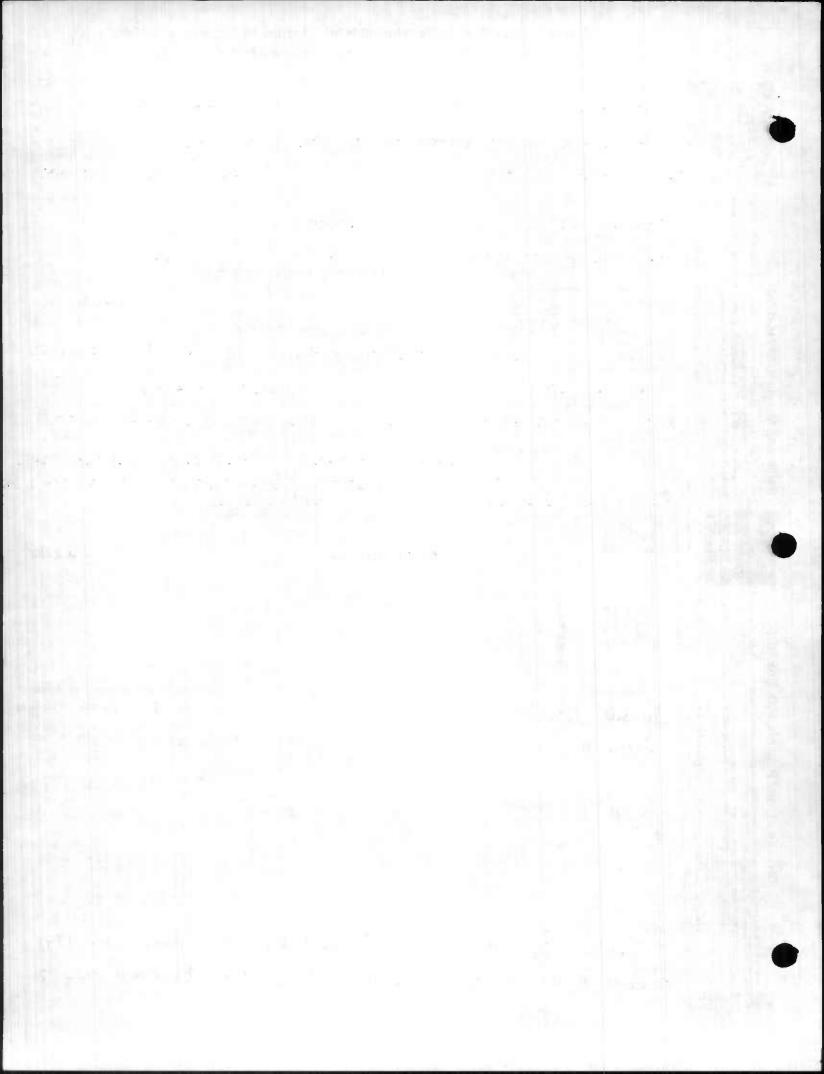
14. Race - American Indian.

Biack, White, etc.

**DHMH 16 Rev 6/95** 

Registrar

31. Dete filed (Month, Day, Year)



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28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. 29c. License number

1112-1 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

PARKVILLE, MO. 21234 ITHEFORD BO.

MARCH 19, 1999

DR. GRACITO-PATRICIO 8903

\$1. Dete filed (Mor MAR'2 2 1999 32. Redistrar's Signature

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARY LOUISE FOX MARCH 17,1999 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death GIEN BURNIE COUNT ARUNDEL If Under 24 Hrs. 8. Date of Birth (Month, Day, Year MARCH 10, If Under 1 Year 9. Birthplace (State or Foreign Country) PENNSYLVANIA 5. Social Security Number Year) Months Days 1 M 2 K F 216-20-4930 78 Yrs. 1921 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND ANNE ARUNDEL GLEN BURNIE 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 1842 RIDGEWICK RD. 21061 Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American indian 11. Marital Status Biack, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3K Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANDREW O'BARA MARY OZECHIJRA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1842 RIDGEWICK RD., GLEN BURNIE, MD 21061 ROSEMARY HANNAN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete MAR. 29 1 Burial 2 □ Cremetion 3 □ Removal from State SACRED HEART OF JESUS CEM. 1999 4 ☐ Dopation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 Approximete interval Between Onset and Death 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. immediete Ceuse (Finel oronam arten disease or condition resulting in death) 10 minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 7 Miknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yas 2 1940 1 Yes 2 No 25. Was case referred to medical examinar? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Neturai 5 Pending

physician end the burial-transit Box 68760 P.O. á signed i Records, peed has e 2 certificate Division of Vitai Physician: this After

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**Physician** /Medical

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or Attending 24 hours after Funeral Dire-letely filled in b Hospital within 2 To the \$

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifier

investigation

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29c. License number

1 Yes 2 No

29d. Date signed (Month, Day, Year) 99

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PANAYIOTIS BALTATZIS, M.D., 8113 HARFORD RD., BALTIMORE, MARYLAND 21234

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) State MAR 2 2 1999

2 Accident

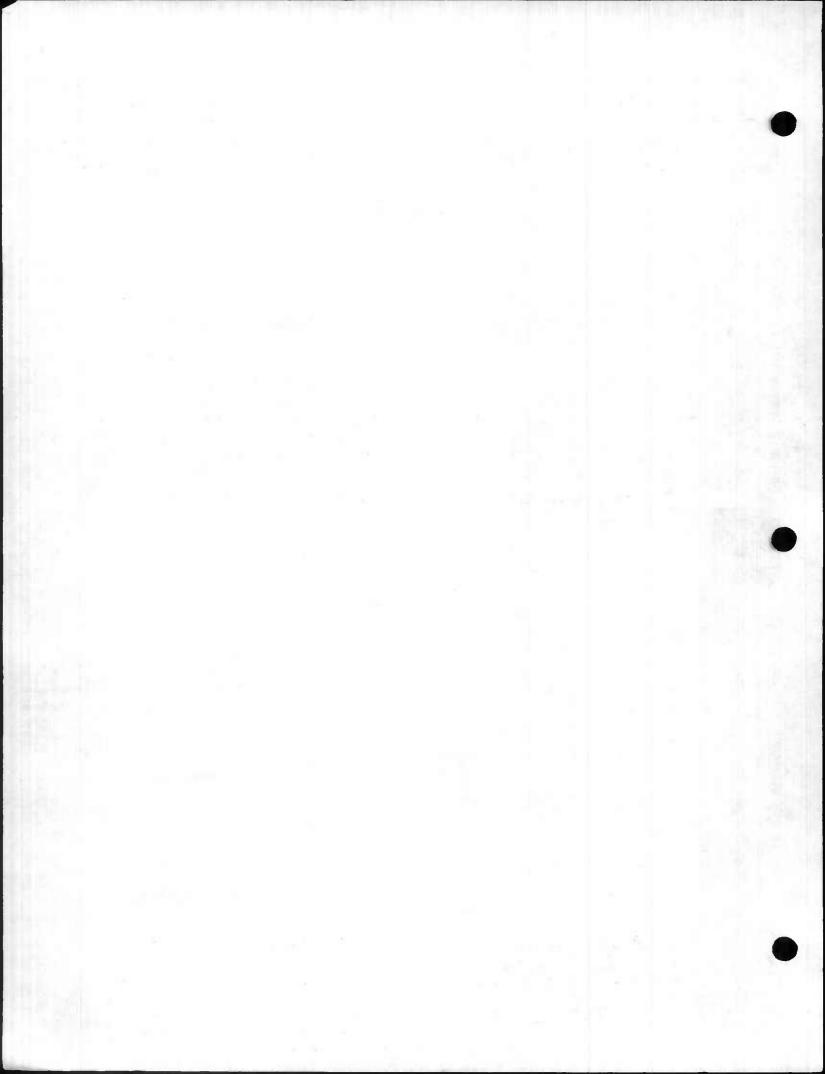
3 ☐ Suicide

29a. Certifie (Check only one)

4 Homicide

32. Registrer's Signature a property

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month DOLORES J. FISCHER 1.15 PM 3 1999 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth CREST VILLAGE mD CARE CENTER BALTO. BALTO if Under 1 Year | if Under 24 Hrs. 8. Dete of Birth (Month, Dey, 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1□M 2QF 217-12-5136 Yrs June 5, 1920 Baltimore, Maryland Usuei Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Baltimore County 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 126 Elinor Avenue 21236 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Rece - American Indian, Bieck, White, etc. 11. Maritel Stetus 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Housewife Housekeeping-Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Michael Eisenreich Clara Gunzelman 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) James Fischer (Son) 3805 Font Hill Drive Ellicott City, Maryland 21042 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) Date 20c. Location - City or Town, Stete 1 XBuriel 2 Cremation 3 Removel from State Most Holy Redeemer Cem. March 19, 1999 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-4625 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in deeth) PULMONARY EmBOLISM minute Due to (or es e consequence of): OMPRESSION FRACTURE wecks

**Physician** /Medical **Examiner** 

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Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 Yes 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) and menner stated. Medical 29e. Certifier (Check only one)

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To the Hospital within 24 hours a To the Funeral I completely filled

State Registrar

WILLIAM M. RUSSELL, M.D. {
31. Data filed (Month, Dey, Year)
32. Registrer's Signeture 31. Dete filed (Month, Dey, Year) MAR 2 0 1999

29b. Signeture end title of certifier



30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

29c. License number

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## Please Type or Print in Black Indeiible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month 0300 March STEVEN CLARK FULK 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN If Under 1 Yeer 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 110 M 2□ F Months Days Yrs. WEST VIRGINIA 43 MAR. 25, 1955 219-66-0579 Usuei Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 Q Yes 2 □ No WASHINGTON HAGERSTOWN 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 728 SUNSET AVENUE USA 21740 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Yeer or Dates: 14. Rece - American Indien, Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usuel Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) (Giva kind of work done during most of working lifa. DO NOT use retired) ROCKY TOP Elemantary/Secondary (0-12) Collaga (1-4or 5+) WOOD PRESERVERS 12 PLANT MANAGER 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) JAMES FULK ESTHER DAILEY 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) ESTHER D. FULK/MOTHER 2700 HIDDEN HILL CT., HUNTINGTOWN, MD 20639 20b. Piece of Disposition (Neme of cemetery, crematory or other plece) Dete 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from State 3/13/99 4 ☐ Donetion 5 ☐ Other (Specify) ROSEDALE CEMETERY MARTINSBURG, WV 22. Name end Address of Fecility 21. Signature of Funerei Service Licensee BROWN FUNERAL HOME, 327 W. KING STREET PO BOX 821, MARTINSBURG, WV 25402 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory arrast, shock, or heart feilure. List only one cause on each line. Approximata Intervel Between Onset end Deeth Immedieta Ceusa (Finai Cardiopularong disease or condition resulting in deeth) Dua to (or as a consequanca of): y log regues Migues. Due to (or es e consequence of): 11 Blue Cureton Due to (or es e consequence of): may 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yee 2 ☐ No augusten laco 24b. Were eutopsy findings evallable prior to 24e. Was en eutopsy performed? completion of cause of daath? 1 Yes 2 No 1 Yes 2 No 26. Placa of Daeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

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permit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Experiment must be notified once.

altimore, Maryland 21215-0020

Examiner Sequentially list conditions, if eny, leeding to immediata ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Physician/Medicai

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case rafarred to medical exeminer? 1 Yes 2□-No 27. Manner of Deeth

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28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury

28c, Injury et Work? 1 Yes 2 No

28e. Plece of Injury - At home, farm, street, fectory, office building, atc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the besis of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Dav. Year)

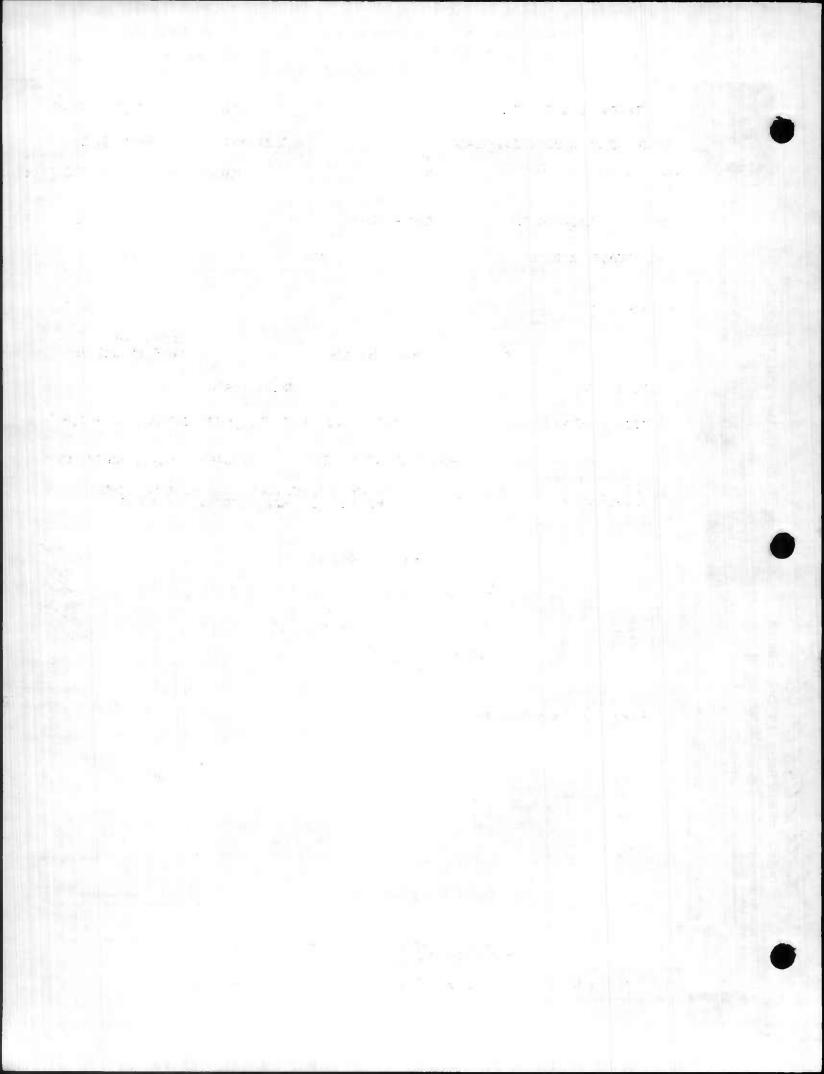
29a. Cartifier

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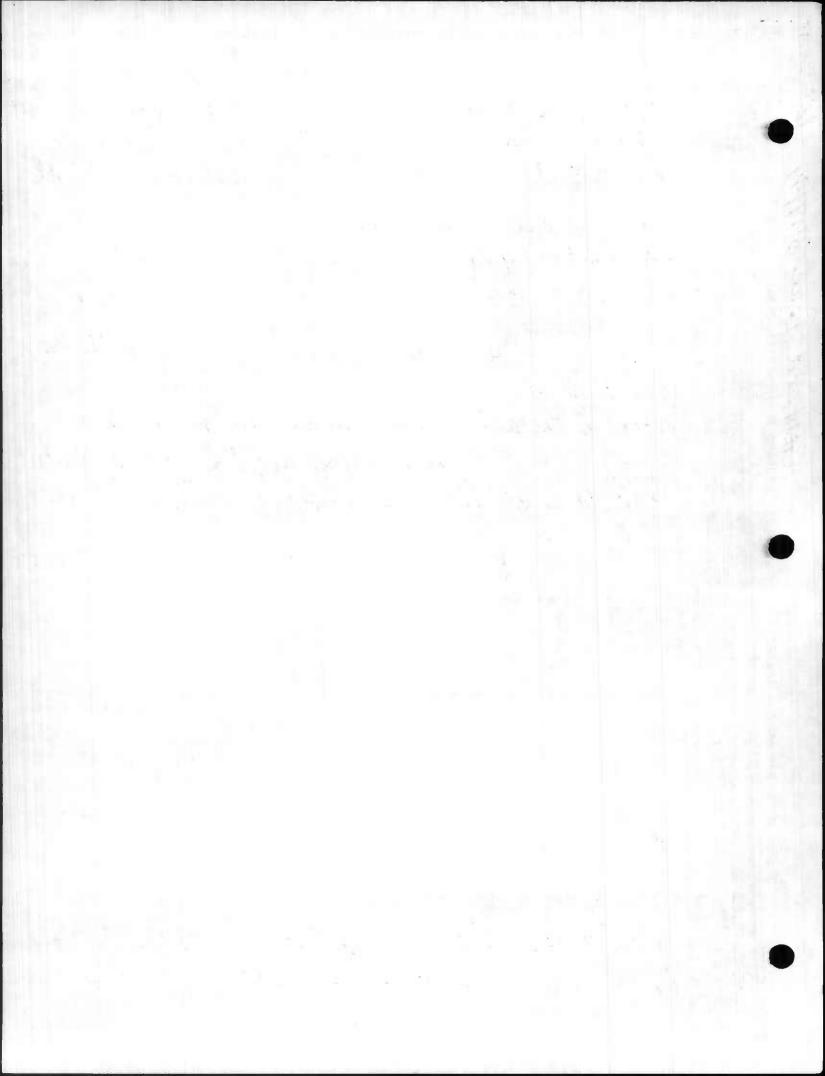
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State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) **Physician** March /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) Examiner If Undar 1 Year 6. Sex 1 M 2 □ F Birthpleca (Stete or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year **Funeral** Days Hours Min Yrs. **Director** 10a, State 10b. Count 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "naturel", or thems 23a or 28a-f shot traumstic event, the Modical Experience must be notified as 1 Yes 2 No Ma Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of Whet Country? 4403 Funeral 14. Raca - Amaricen Indian, 12. Was acadant Ever in U,S.
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S 2 □ No
Give Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 11 Marital Status Black, White, etc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life, DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Peges 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other treumetic event, the Med and DRCE. Elementery/Secondery (0-12) College (J-4or 5+) 0 18. Mother's Neme (First, Middle, Maidan Sumama) 17. Fether's Name (First, Middle, Last) Be MORNEY Lo 19e. Informant's Name/Relationship (Type 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Jappattsville 2616 noenly. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition March 18 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) EVANS FUNCER Chapel 4 Donetion 22. Name and Address of Facility 21. Signature of Funeral Service Licenses vans 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Concer lears Examiner Due to (or es e consequence of) Physician/Medical Examiner ettending physician and for use as the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequence of) Box 68760. Due to (or es e consequence of) 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were eutopsy findings aveileble prior to completion of causa of deeth? 24e. Was an autopsy should peen s The law hes 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attanding Physician: 25. Was cese referred to medicel examiner? Be 26. Piece of Death (Check only one) Other: 4 | Nursing Home 5 | Residence 8 Other (Specify) Hospical 9 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA After this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 Yes 2 No death. To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner as stated.
2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier Medicai 29b. Signature and tipe of sortifie 29d. Data signed (Month, Day, Year) 29c. Licensa number March 17, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto md. 21204 N. Charles St. 6701 31. Data filed (Month, Day, Year) MAR 2 2 1999 32. Registrar's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month GERTRUDE 3.25 AM 4e. Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Catons ulle Villa trederick If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) 1 M 2 XF Deys 216-20-7308 73 Yrs Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Saltimore 10e. Street and Number 10g. Citizen of Whet Country? 3600 anklin Street 21229 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes: 14. Reca - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorcad 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retirad) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) loth grade Manager 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Charlie Williams Kosetta 19e. fnforment's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 2848 - Uncle Mulberry Street Baltimore W. rantes 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State Zion 4 Donetion 5 Dother (Specify) emetery 21. Signeture of Funeral Service Licansee 21215 land 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line. Avenue Approximate Interval Between Onset end Deeth Immediate Ceuse (Finel Vanian diseese or condition resulting in deeth) Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting In death) Lest Due to (or es e consequenca of): Due to (or es e consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? SELNO 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 32No 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

physician s the buriel Box 68760. igned by the atte P.O. Records. page 2 should certificate Division of Vital director, this funeral After

Physician/Medical Examiner ρ Completed Be

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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Нета 23а

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any Injury or other traumatic event. It a

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

Director

Completed by Funeral

the Maryland

Hospital or Attending Physician: Medical Certification: To within 24 hours after death. To the Funeral Director: A in by completaly filled

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State Registrar 29b. Signeture end title of certifier

4 - Homicide

29a, Certifier (Check only one)

29c. License number 47683

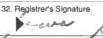
Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, dete end placa, end due to the ceuse(s) end menner steted. 29d. Dete signed (Month, Dey, Year)

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

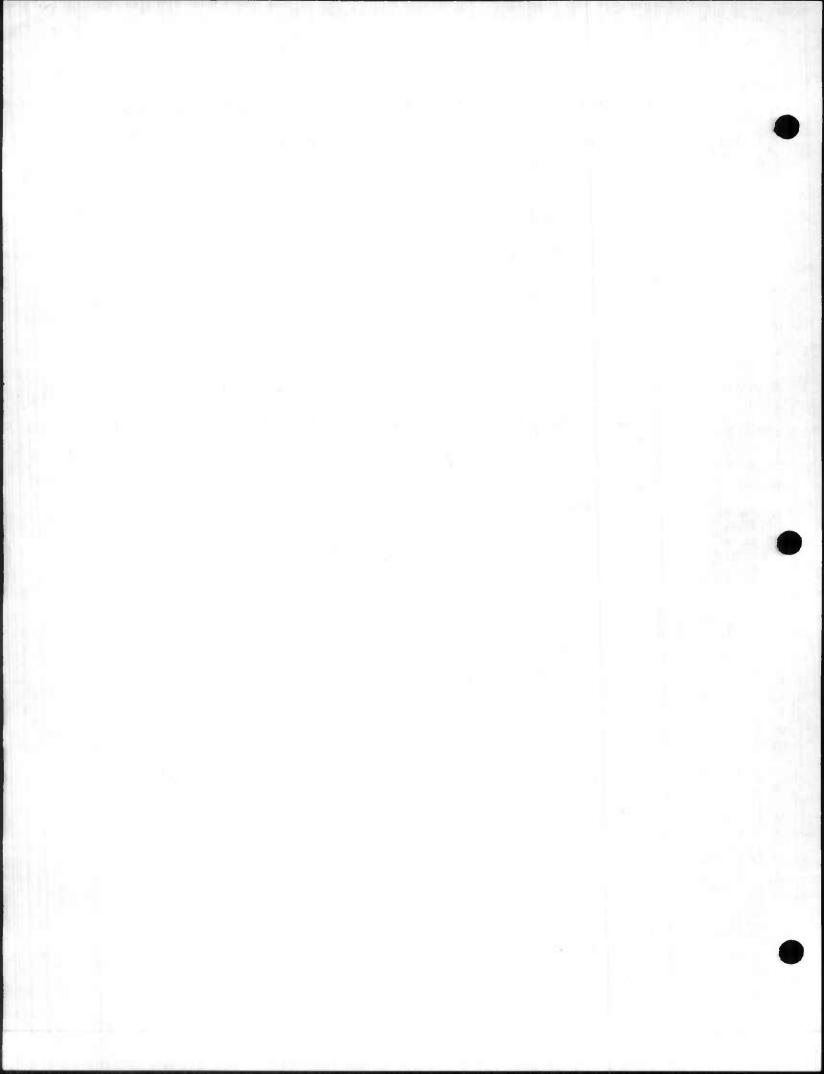
Raymond Miller 25 Main Street, Soute 200

31. Dete filed (Month, Day, Year) MAR 2 2 1999



28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

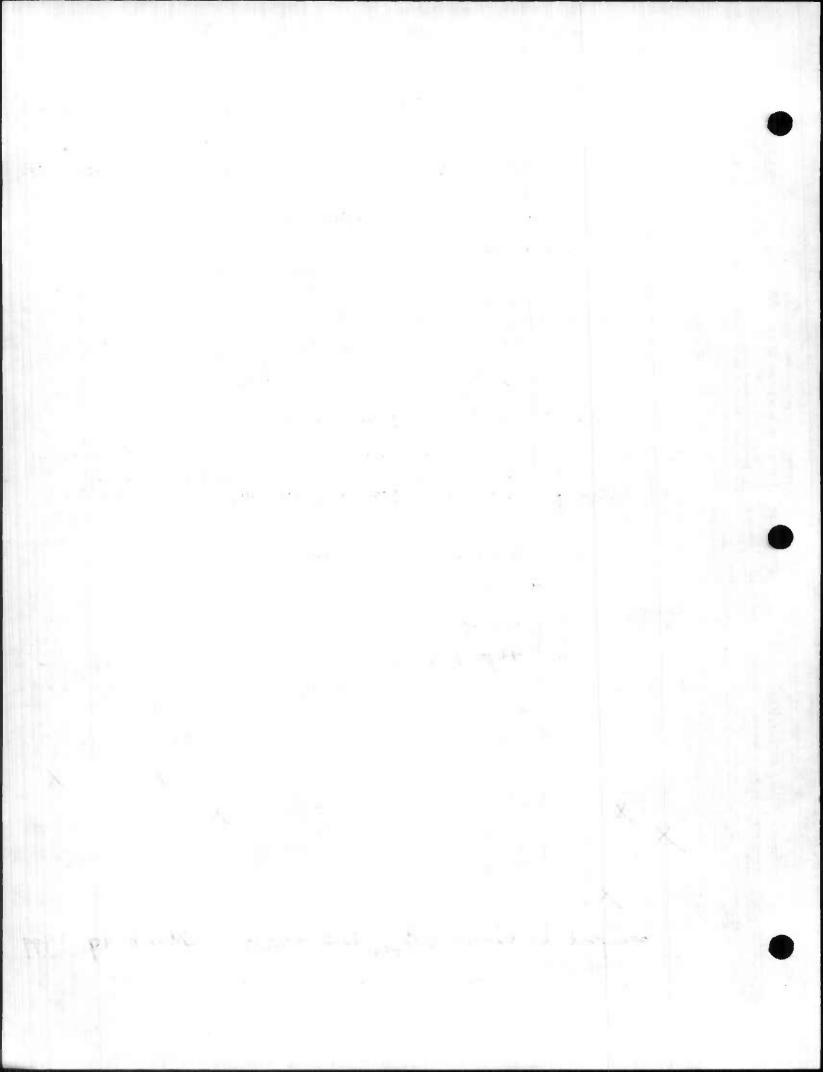
Ruskstown



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Deeth Month Yaar **Physician** Evelyn M. Grupp March 19, 1999 11:00 a.m. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5435 Omaha Avenue Baltimore City If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) July 14, 19 5. Social Security Number Birthplace (Stata or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Months 1 M 2 F 219-10-9867 90 Yrs 1908 Baltimore, Director Md. Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits , or items 23s or 28s-f show r than "natural", or frems 23e or 28e-f sho the Medical Examiner must be notified at 1 Yas 2 No Director N/A Md. Baltimore City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5435 Omaha Avenue 21206 United States Funeral 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status hours after 1 ☐ Yas 2 🗷 No If Yas, Giva 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specity: White Specify: ģ 3 Widowed 4 □ Divorced Year or Datas: Completed Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Hygiene. Elementery/Secondary (0-12) Collega (1-4or 5+) Printer Printing permit. Pages 1 and 2 should be till.
Department of Health and Mental Hy.
Important: If them 27 is marked offer any Injury or other 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middla, Maiden Sumama) a Charles Fick Mary Street 0 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Andrew E. Amereihn (Son) 5435 Omaha Avenue 21206 Baltimore, Md. 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Parkwood Cemetery 3/23/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funeral Sarvice Licensee Milton & Knight Jr 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on sech line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final disaese or condition resulting in deeth) /Medical AS piration Examiner Sequentially list conditions, if any, laading to immediata cause. Entar Undarlying Cause (Diseasa or Injury that initiated evants rasulting in death) Last and Due to (or as a consequence of): physician as the burial-Box 68760 dementia Physician/Medical Dua to (or as a consequance of): attending Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 94 signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Wara autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? peed has The certificate To the Hospital or Attending Physician: within 24 hours after death.

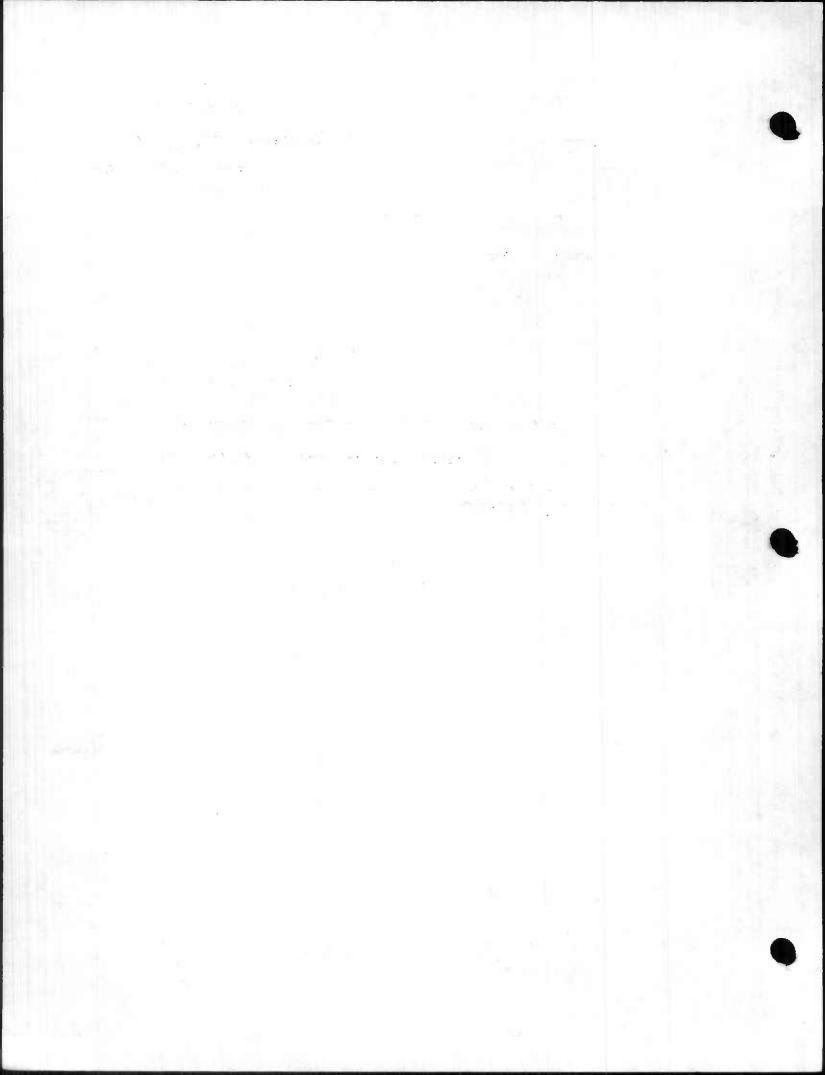
To the Funeral Director: After this certifica Be 25. Was casa rafarred to medical examinar? 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1□ Yas 2 No ome 5 Rasidence 6 Othar (Specify)
28d. Dascribe how injury occurred Certification: To 27. Mannar of Death 28b. Time of 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 1 Netural 2 Accidant 5 Panding invastigation 1 Yes 2 No 6 Could not be determined 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number 30. Name and address of person who completed causa of daath (Item 23a) (Type, Print) Luhar, M.D. 3509 Eastern Avenue Dr. Mukesh Baltimore, Maryland 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State . 2000 MAR 2 2 1999 Registrar

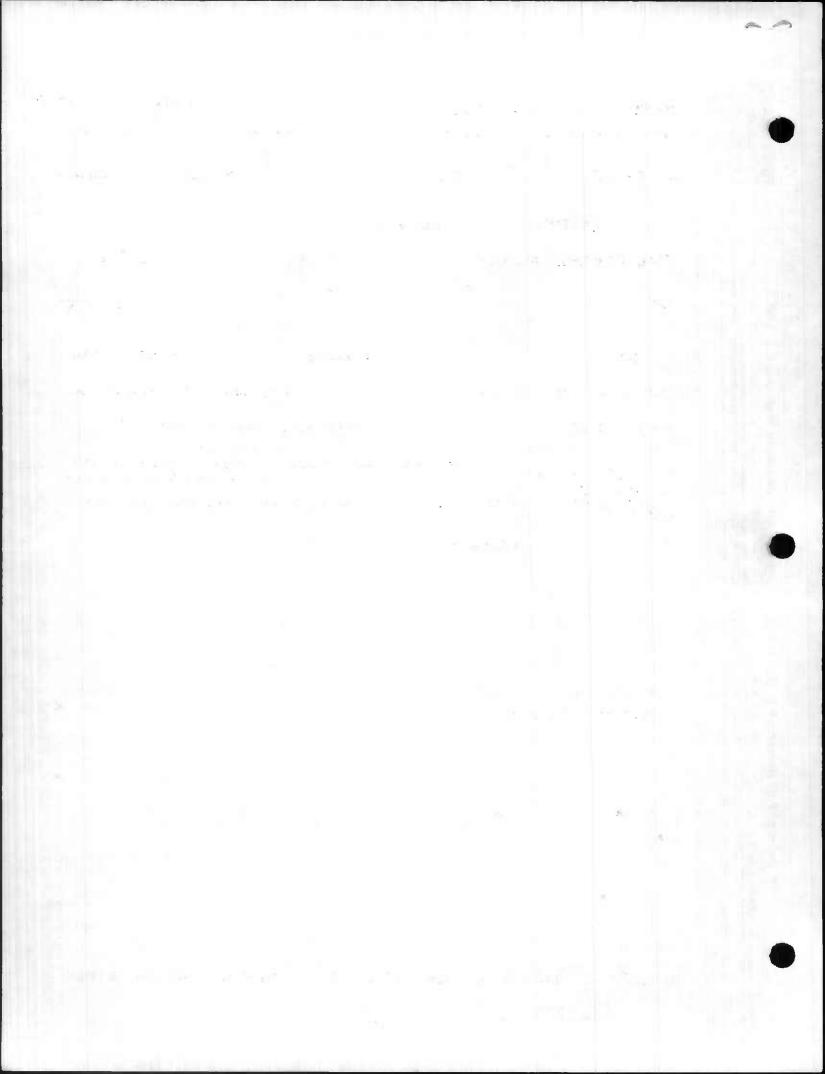


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Nama (First, Middle, Last) 3. Time of Death Day Year **Physician** Minnie B. Goldsmith March 17, 1999 6:45 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2813 Cheswolde Road N/A Baltimore 8. Dete of Birth (Month, Day, Year) Sept. 27, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 10 M 20 F Country) Maryland 219-22-9573 93 Yrs. 1905 Director Usuel Residence of Decedent the Meryland 10s. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be nothing at 1 Yes 2 No Director Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2813 Cheswolde 21209 U.S.A. Road death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Maritel Status i filed within 72 hours efter il Hygiene. other than "natural", or ite 1 Yes 2 No if Yes, Give Year or Dates: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White P 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Teacher Education permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If item 27 Is marked oths any Injury or other traumatic avant. pince. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Lula Schuppner George F. Bach 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Mrs. Anne Sterlock/Daughter 9221 Sandra Park Road Perry Hall, Md. 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete ty□ Burial 2 ☐ Cremetion 3 ☐ Removel from State Druid Ridge Cemetery 13/22/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 1050 York Road 21. Signeture of Funeral Service Licenses 22. Name and Addrass of Fecility Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Pert1. Enter the disease, or commications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of one cause on exprime. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Finel PNOUMBNIA disease or condition resulting in deeth) Examiner Due to (or as e consequence of): Examiner AckINSONI 011000 physician and the bunal-transit that the deeth certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records. þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: director 25. Wes case referred to medical examiner? 89 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending 1 Natural n 24 hours after death.

Ne Funeral Diractor: After pletely filled in by the fun 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 29e. Certifier Medical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certific 49 pérstir leted bause of death (Item 23a) (Type, Print) 30. Neme and addr 1828 6 LOCAL MOL PILOSDILLE up, n, Day, Year) 32. Registrar's Signature State MAR 2 2 1999 Registrar



1. Decedant's Nama (First, M	liddla, Last)			tificate of		2. Data of De			ima of Deeth
MABLE I	Z. HARC	FROUE				MARCH	d ≥Pay, 19	39 29:	15 PM
4e Escility Neme (If not instit	ution, giva street and n	iumber)				or Location of Deat	h 4c. County	of Death	0
Saint Josep	h Medica	1 Cent	er		Towso		De	KI CIMOF	E.
5. Sociel Security Number	6. Sex 1  M 2 F	7. Aga (In yrs		If Under 1 Year Months Day			rth ay, Year)	9. Birthpleca (S Country)	tate or Foreign
215 - 54 - 2231 Usual Rasidanca of Deceden		88	Yrs.			JULY 9	2,1910	VIRGIA	JIA
10a. Stata 10b. Con		10c. C	ity, Town or Lo	ation				10d. Ins	ide City Limits
MD RA	LTMORE	P	AekVII	LE				1 🗆	Yas 2 No
10e. Street and Number	CI II TO ICC		TELVIC	10f. Zip Code			10g. Citizen of	What Country?	
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1 Nevar Married 2 □ I	Married 1 ☐ Yas	a 2 ☑ No Giva Datas:		□Yas 2⊡N			Specif		
	ident's Education		16a. Deced	ent's Usuat Occ	upation		16b. Kind of B	usinass/Industry	C
(Specify only hi Elementary/Secondary (0-	ghest grada complatad	(1-4or 5+)	(Giva	kind of work don OO NOT usa rati	a during most of w red)	vorking			
10	(2) Conege	(1-401 5+)		MARKI	20		MENS	CLOTHIN	G
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WARREN	B. BRU	CE			Cor	SINNE	M. AA	DERSON	
19a. informant's Neme/Ralat	ionship (Type, Print)		19b. Mailin	g Addrass (Stra	et and Number or i	Rural Route Numb	ber, City or Town	Stata, Zip Coda)	
PAM MYER	S		1745	FORRES	TAVE. P	PARKVILLE	MD. a	4234	
20a. Mathod of Disposition  1 ☑ Burial 2 ☐ Cramet	ion 3 □Ramovel from		cematary, cran	sition (Nama of netory or othar p	lace)	MARCH 24	20c. Location	City or Town, St	ata
4 Donation 5 Otha	r (Specify)			MPM I		1999		LLE MD	
21. Signature of Puneral Sen	Ace Licensele	1 1110	22	Name end Add	lrass of Facility	evans ch	APER OF	MEMORI	EZ
236 Part 1 Enter the disease shock, or heart failura.	1 - We	blls_	2 8	800 HAR	FORD RD	, PARK	VILLE, M	0 2123	4
Sequantially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last	b	Dua to (	or as a conseq	uance of):				t t	
rasulting in death) Last	d	Dua to (	or as a consequ	Janca of):					
Part II. Other significant con	ditions contributing to	death but not ra	sulting in tha ur	darlying causa	givan in Part I.	23b. Dio	tobacco use co	entribute to the c	
CEREBRAL T	THROMBOSIS					10	Yea 2□ No	3 Probably	4X Unknow
							s an autopsy formad?	24b. Were aut available completic of death?	prior to on of causa
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axaminar? 1 ☐ Yas 2 ∰ No	Hospital:	¶Inpatiant 2□	ER/Outpatien	t 3□ DOA	Other: 4 Nursing	g Homa 5 ☐ Ras	sidance 6 Oti	nar (Specify)	
27. Mannar of Daath	28a. Dat	e of Injury onth, Day Yaar)	28b. Tima of Injury	28c. In	jury at fork?	28d. Describe	how Injury occu	rred	
1 Nature   5   Panding   (Monin, Day Year)   Injury   Work /   2   Accident   3   Suicide   4   Homicide   Homicide   Accident   28a. Place of Injury - At home, farm, streat, factory, offica						28f. Location (Street and Number or Rural Routa Number, City or Town, State)			
	ifying Physicisn: To thical Examiner: On the and ma								ausa(s)
29b. Signatura and title of ce	rtifia				nsa numbar		29d. Data signa	ad (Month, Day, Y	'ear)
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30. Nama and idensity of per	MEHTA M.	D 76	01 05	LER DR	IVE, TO	WSON, M	1ARYLAN	D 21204	1

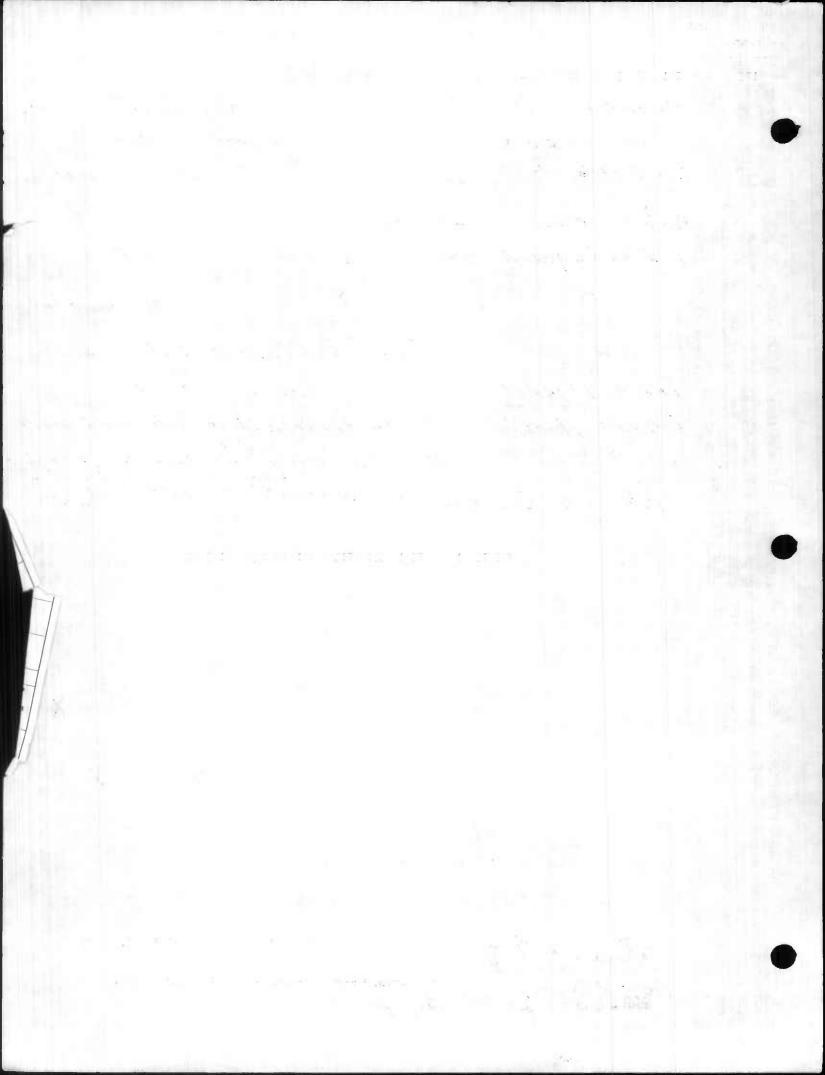


WRC 99-1650-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. ANDREW State of Maryland / Department of Health and Mental Hygiene HARRID Certificate of Death ITEM: 23 PART I, 27 PER MEO G771 5-6-99 J.A. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Yaar **Physician** JARRIO NdRew MARCH 18, 1999 5:40 PM. /Medical 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 1115 N. LONGWOOD ST. BALTIMORE if Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months 1XM 20 F 219-10-8916 Yrs. HALLARY 30,1926 **Director** Usual Residance of Decedent deeth with the Merylend 10d. inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No Director MARYband none 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21216 1115 Longwood Funeral 12. Was Decedent Evar in U,S. Armed Forcas?
12 Yas 2 □ No If Yes, Giva Year or Dates: /942 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours efter Hygiene. 1 Never Married 2 Married 1□ Yes 2 No Saltimore, Maryland 21215-0020 à American 3 Widowed 4 Divorcad 120 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry /Secondary (0-12) College (1-4or 5+) Huto Mechanic markad other 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be permit. Pages 1 end 2 should be Department of Health end Mental 1-RANK 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . item 27 i 3600 W. FRANKIN BAHimore Md other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State important: If its any injury or or once. 1 Burial 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) retro MAKY of Funeral Sarvice License WALCACE FRANKlin St nel 3Altimore, 3405 W. 21229 the decasa, or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or raspiretory arrest, Approximete Interval Between Onset and Daath Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or as a consequenca of): Examiner physician end the bunal-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequenca of): 98 for use es signed by the e 23b. Did tobacco use contributa to the causa of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknow 1 Yes 2 No 3 Probably Records, þ should l 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to complation of cause of deeth? Completed certificate has b Yes 2 □ No 2□ No Division of Vital or Attending Physician: Be 25. Was case refarred to medical 28. Place of Death (Check only one) Hospital: To Other: 4 Nursing Home 5 Nesidenca 8 Other (Specify) 1XYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of Injury 28c. Injury at Work? Certification: After 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No deeth. 2 Accident after deet Director: 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 2 4 Homicide Funeral Dire Hospital 24 hours 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Fune Completely fi (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifie 2) penloy O.C.M.E. MARCH 19, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 SONORE

32 Registrat's Signature

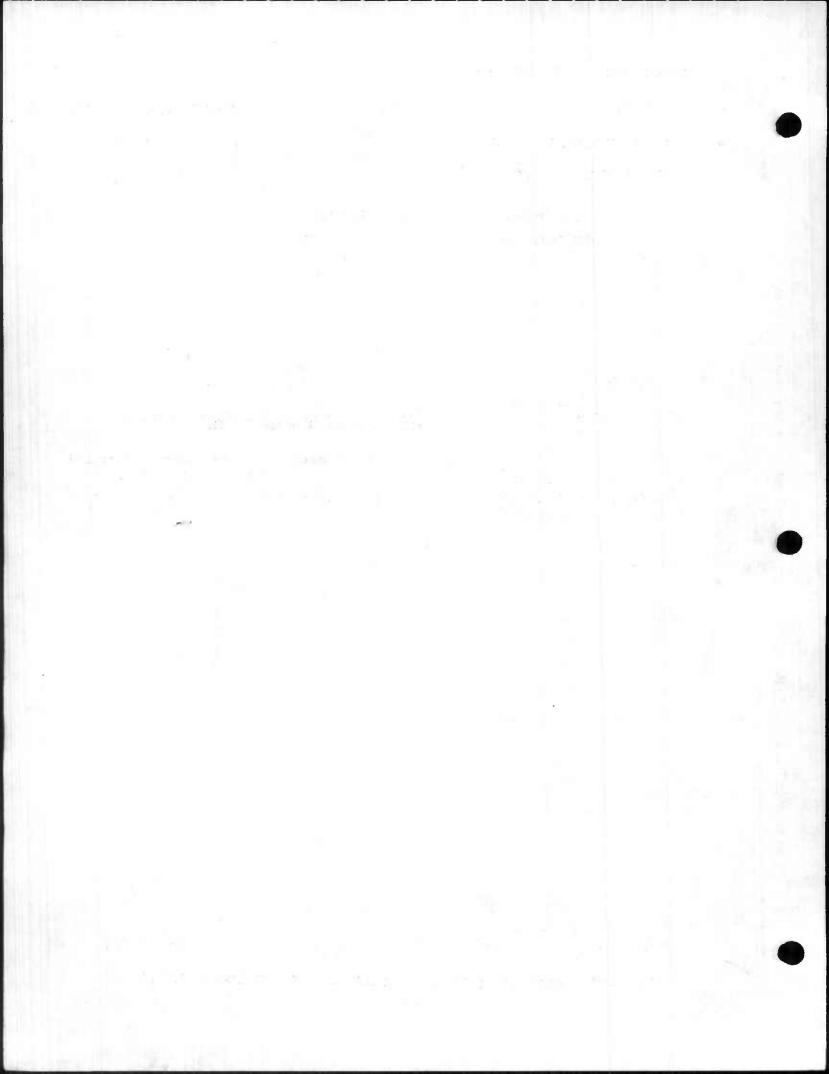
State Registrar



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	_	I tems: 10b-f,		F.H G-769		and / Depage 19 reb <i>Ce</i>						Reg. No.	U.S	3. Time of Death	
Physician /Medical	VIOLET HAYWARD									Month Dey Year MARCH 16, 1999  or Location of Death 4c. County of Death			11:30 pm		
Examiner	1							1	ib. City, To	wn, or Li	ocation of Death			_ = 0.0	
Europe !	5	RIVERVIEV  Social Security Nur		ING CENT 6. Sex	_	yrs. last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Dete of Bird		TIMOR		
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and **	-		10b. County		10c.	City, Town or Lo	cation							Od. fnside City Limits	
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r itams 23a or 28a-f s niver must be norried Funeral Director	1	0e. Street end Numb	per 2122	Tinton Way			10f. Zip	Code	21000	)		10g. Citizen of	What Count	Irv?	
3a o		306 Parkside Drive 10f. Zip Code 21009								7		U.S.		.,	
ms 2	1	1. Meritel Stetus		12. Was Dec	cedent Ever i	n U,S. 13.1	Vas Deced			gln? (Sp	ectfy Yes or No Rican, etc.)		e - America	an Indian,	
d other than "natural; or items 23s or 28s-f sho event, the Medical Evaminer must be nortified at BE Completed by Funeral Director		1 Never Married 3 Widowed 4	Armed F ad 1 Tyes If Yes, G Year or I	2 ANo	1	f Yas, spec 1 ☐ Yes 2	**	Specify:		Rican, etc.)	Specif	Bleck, White, etc.			
ted bat		/Saarit	5. Decedent	's Education		16a. Dece	lent's Usua	Occup	ation			16b. Kind of B	usiness/ind	ustry	
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is marked other than "natural", or items 23s or 28s-f show reumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	'	7. Fether's Neme <i>(Fi</i> Edward W		Last)							me (First, Middle, Maiden Si (Unknown)		lumame)		
27 is marke er traumatic		9a Informent's Nam Melvin H	e/Relationsh ayward	nip (Type, Print)		19b. Mallir 306 3122	ng Address Parks Tipton	(Street Way	and Number Driv Abino	er or Run	Rural Route Number, City or Town, State, Zip Code)  Baltimore, Maryland 21200  Md. 21009			Code) !1206	
Department of health a important: if item 27 is any injury or other tre once.	2	0a. Method of Dispose 1 ☐ Buriel 2 ☒ 4 ☐ Donetion 5	Cremation	3 □Removal from	State	b. Placa of Dispo cemetery, crer Balto./\	sition (Nem natory or ot	e of her plea	e)		Date	20c. Location	City or Tov	vn, State	
ing a	2	1. Signature		- 1	,		. Name and				hn C. N			Lara	
EES		1/1. 0/1.									Baltimore, Maryland 21206				
ysician Medical aminer	1	23a. Part Enter the shock, or heart f mmediate Cause (Fir isease or condition esulting in death)		0	Herrin	Atau o (or as a conseq	ئىدلىدى:		_		^ =		1	Approximete Interval Between Onset end Death	
physician end the buriel-trensit	Siff	Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):													
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for us				d										,	
igned by the ettending be detached for use es by Physician/Me	P	art II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.  Perel calvacolar Acadecets.								23b. Did tobacco use contribute to the cause  1  Yas 2 No 3 Probably 4 2			/		
spen s should eted	-	Aueoria									24a. Wes	an autopsy med?	com	ra autopsy findings lleble prior to apletion of cause eath?	
s certificate hes t director, page 2 s	_	Atrial Ji	Scale	etien, P	riabit	es, Bre	out (	au	cel		1 🗆 Y	es 22 No		Yes 2□ No	
s certific director,	2	5. Was case referred examiner?	/	Hospital:				Othe			(Check only o				
a a a	27	1 Yes 2 No		111		ER/Outpatien		1	4 CJPNU		Home 5 Residence 6 Other (Specify)				
To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1		27. Mennet of Deeth  12 Netural 5 Pending Investigation  3 Suicide 6 Could not be							No	28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number.					
illed in b		4 Homicide	determin	build	ing, etc. (Spe						City or Tow	n, State)		•	
pletely fill	2	9a. Certifier 1E (Check only 2 one)	☐ Certifying ☐ Medical E	Physician: To the xaminer: On the b and man	best of my k asis of exami ner stated.	nowledge, deeth Inetion and/or inv	occurred el estigetion, i	the tim	e, date and pinion, deet	d plece, a h occurr	and due to the ded at the time, d	ause(s) and me fate and piece,	enner es sta end due to t	ited. the ceuse(s)	
omploample Me	29	b. Signature and title	e of cartifier				29c.	License	number			29d. Date signe	d (Month, D	ay, Year)	
		Meso	ue R	herous	Qu		01	0 (	(6)			3/18	-199	,	
	30	DR. MI		ho completed causes	se of death (II 5517			HIG	HWAY	BAI	TIMORE,	MD. 21	1225		
State Registrar	31	. Date filed (Month, I	Day, Yeer)		legistrar's Sig	£,	10	/	,			F			

DHMH 16 Rev 6/95



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vernice Imel 10:45pm Mar. 17, 99 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 407 East 22nd Street Baltimore If Under 1 Yaar | If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 M XXF 212-36-7217 57 Yrs. NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 407 East 22nd 21218 Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedant Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HomeCare in home 12th Grade 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Malden Sumame) Moore Hannah George E. Gaylord 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20793 8914 River Island Road Savage, Maryland Apt. Sanders 20c. Location - City or Town, State #104 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Garrison Forest VA Cem. 03-23-99 Owings Mills Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Othar (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Servica Licensee WM.C.March FH 1101 E. North Avenue enu an 23a. Pirt1. Enter the disease, of complication shock, or heart feilure. List only one ca hat caused the death on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intarval Between Onset and Death Immediata Causa (Final disease or condition resulting in death) (amonths Due to (or as a consequenca of) Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events Dua to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown 24a. Wes en autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes No

**Physician** /Medical Examiner

Box 68760.

P.O.

Division of Vital Records,

The law requires

Physician:

permit. Pages 1 and 2 should be fitted bepartment of Health and Mental Hy Important: if Nem 27 is marked oth any Injury or other traumatic event page.

Physician/Medical Examiner and cortificate be

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Directo

Funeral

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7 is marked other than "natural", or frame 23a or 28a-f sho traumetic event, the Midical Examiner manife in littled at

with the Maryland

death

filed within 72 hours after Hygiena.

attending physician a for use as the burst-96 B signed to þ Completed 188 certificate Be 2 After this **Every** Certification:

29d. Date signed (Month, Day, Year)

examiner?		26. Place of Death (Check only one)									
1 Yes 200	No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐	Nursing Home 5	Home 5 Residence 6 □Other (Specify)						
27. Manner of Death 1 Natural 2 Accident	n 5 🗌 Pending Invastigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		scribe how injury occurred					
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - Ath building, etc. (Speci	nome, farm, street, fac	28f. Loca City	28f. Location (Street and Number or Rural Route Number City or Town, State)						
29e. Certifier (Check only one)						to the cause(s) and manner as steted. time, date end plece, end due to the ceuse(s)					

Director after ò

within 24 hours a To the Funeral (

4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Barry Meisenberg, MD Univ. Of Maryland 22 S. Greene Street

Registrar

MAR 2 2 1999

29b. Signature and title of cartifier

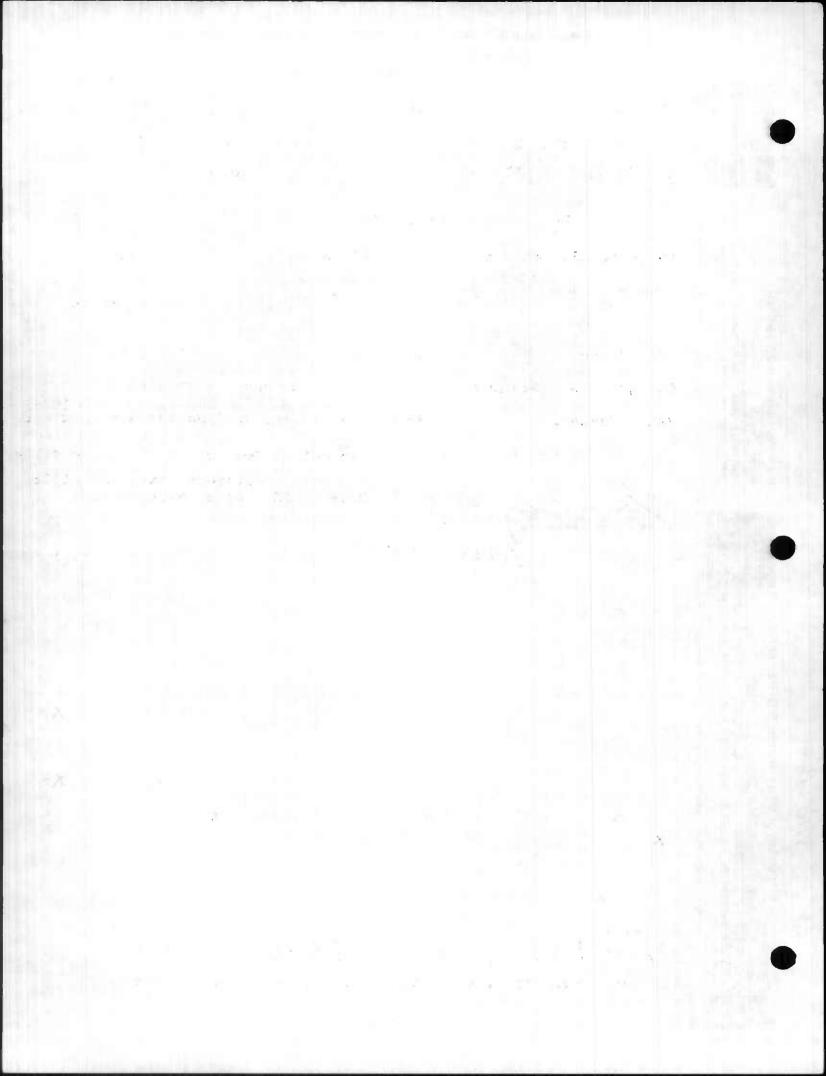
31. Data filed (Month, Day, Year)





29c. Licanse numbe

DHMH 16 Rev 6/95



### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Maech 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) 3altimoe If Under 1 Year Birthpiece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Deys Hours Min. Year) 8386 1 M 2 XF -26-Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1234 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Baca - American Indien. 11. Maritei Status Biack, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorcad 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) eamstres. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden St 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Reletionship (Type, Print) 20b. Piace of Disposition (Neme of cametery, cremetory or other plece) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Match 21. Signature of Fyrieral Service Licenses 22. Name end Address of Facility varis 23a. Part . Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Ceuse (Final disease or condition resulting In death) Stroke Days Due to (or as a consequenca of): Due to (or es a consequence of): Due to (or as a consequenca of): 23b. Did tobacco usa contribute to the cause of death? 3 □ Probably 4 Wunknown 1 Yes 2 No 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24a. Was en autopsy performed?

**Physician** /Medical Examiner

The law requires that the death certificete be axecuted

Division of Vital Records, P.O. Box 68760,

Important: If it any Injury or o

permit. Pege Depentment of

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

Director

Peges 1 and 2 should be filed within 72 hours after deeth with the Marylend nent of Health and Mental hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

altimore, Maryland 21215-0020

tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at

Physician/Medical Examiner attending physician and for use es the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest been signed by the should be detached

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Certification: To

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tor: After this certificate has I the funeral director, page 2:

After this

Director.

24 hours a

To the F

filled in by

Hospital or Attanding Physician:

Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i.

1 Yes 2 No 26. Piece of Death (Check only one)

1 ☐ Yes 2 ☐ No

25.	Was case		to	medical
	exeminer?			
27.	Menner of	Deeth		

5 Pending investigation

6 Could not be determined

28e. Date of Injury (Month, Dey Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Neturel

2 Accident

3 Suicide

4 | Homicide

TECartifying Physician: To the best of my knowledge, death occurred et the time, date and piace, end due to the cause(s) and manner as stated.

Image: Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

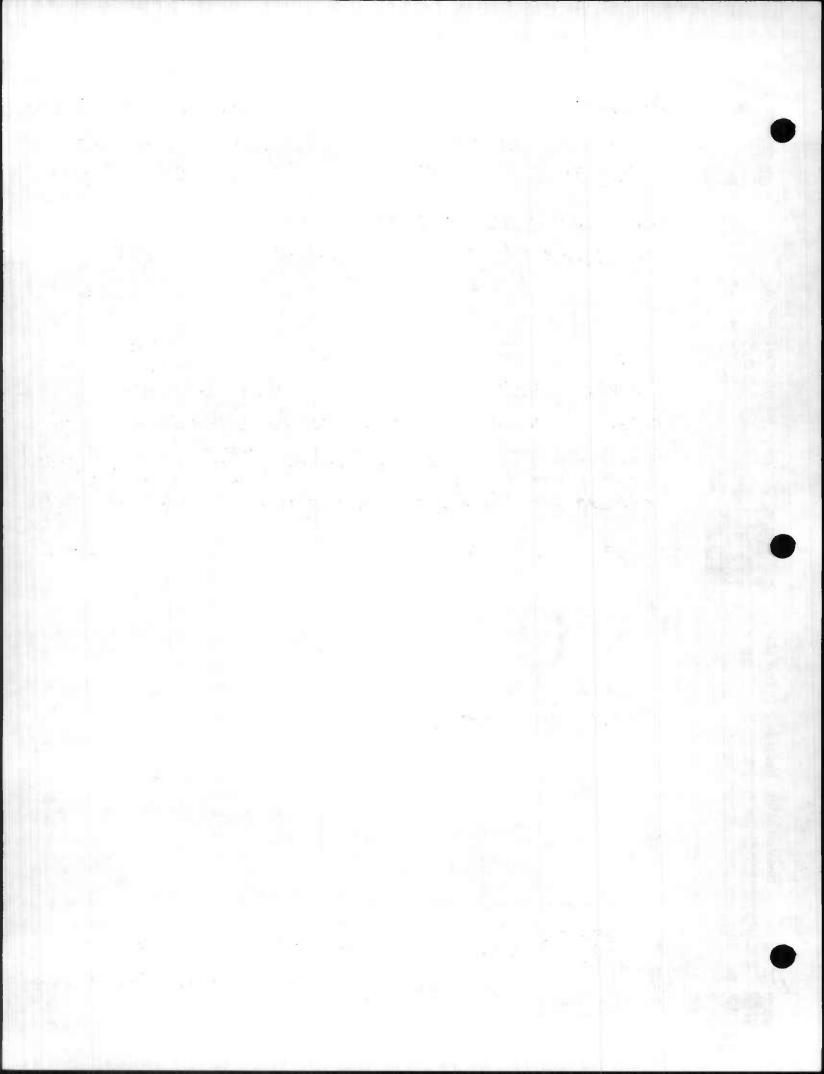
29b. Signature and title-

29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print

32. Registrer's Signature

State Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 10:55 AM JULIAN ELIZABETH 1999 MARCH /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner BEL AIR RD HARFORD LEESWOOD If Under 24 Hrs. If Under 1 Yeer Birthplece (State or Foreign Country) 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 KF Yrs. SEPT. 11, 1917 NORTH CAROLINA 218 26 1605 81 Director Usuel Residence of Decedent 10b Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No BELAIR Director MARYLAND HARFORD 10f. Zip Code 10a Street and Number 10g. Citizen of What Country? "natural", or items 23s or 21014 814 LEESWOOD RD UNITED STATES Funeral 14. Rece - American Indian Black, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Status 12. Was Decedent Ever in U.S. Armed Forces? 72 hours after 1 ☐ Yes 2 No If Yas, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: WHITE 2 3 Widowed 4 □ Divorced Yeer or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be lited within 72 Department of Health end Mentel Hygiene. Important: if item 27 is marked other than "neth any injury or other traumatic event, the least-ong. Elementery/Secondary (0-12) College (1-4or 5+) DOMESTIC HOMEMAKER 11 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be MINTON (MNKKOWA) ETHEL HUGHES 2 19e. informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAY DAWSON 3708 REXMERE RD; BALTIMORE MD 21218 DAUGHTER 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ■ Buriel 2 □ Cremetion 3 □ Removel from State 23/99 HAPPY VALLEY CEMETERY ELIZABETHTON, TN 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA STEPHEN D. LOHRMANN P.A. 21. Signeture of Funeral Service Lice 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate Interval Between Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel METASTATIC CANCER OF BRAIN & BONES MONTHS diseese or condition resulting in deeth) Examiner CANCER UNKNOWN PRIMARY physician end s the buhel-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 ☐ Yea 2 ☐ No HYPOTHYROIDISM à 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? VENOUS THROMBOSIS 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Placa of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. injury et Work? After 5 Pending Investigation or Attending 1 Neturel ne Hospital or Attending in 24 hours after death. Ne Funeral Director: Afte pletely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. Medical 29e. Certifier completely (Check only one) To the P within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 1999 ar MARCH 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) 21014 M. ABHYANKAR BEL AIR NORTH AVENUE

State Registrar 31. Dete flied (Month, Dey, Year)

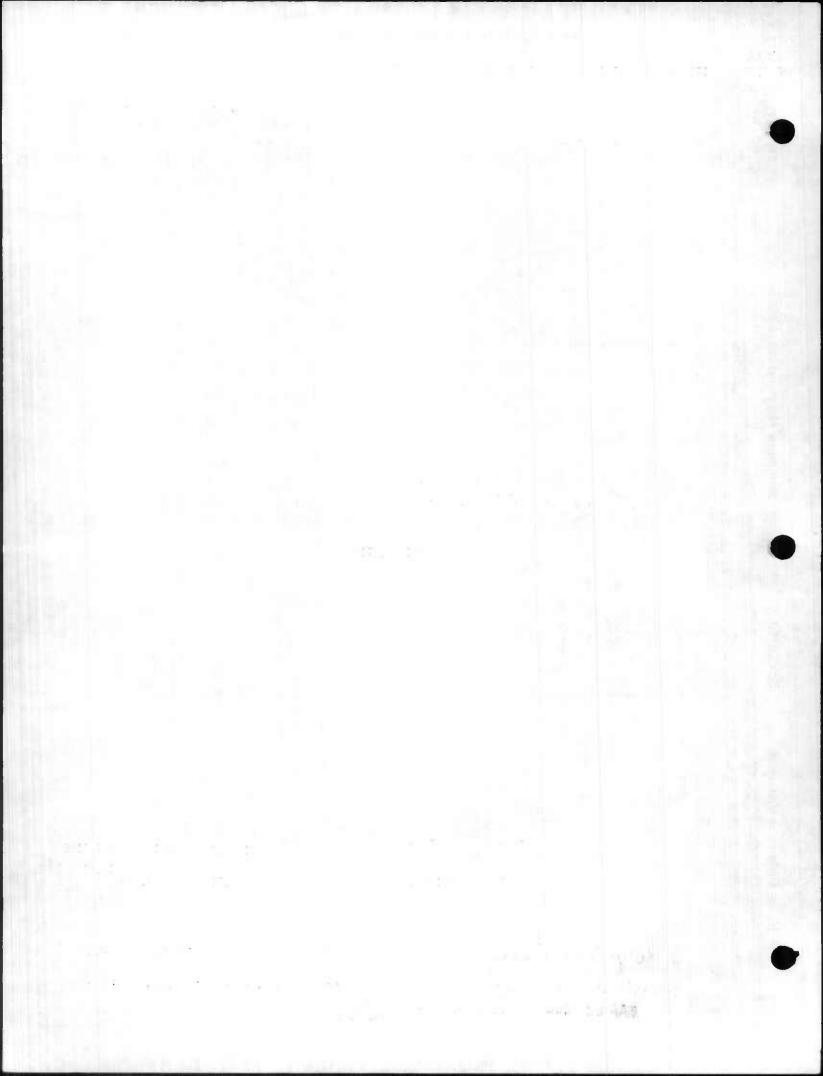
11. AR 2 2 1999



MANUFACTURE OF THE PROPERTY SHAPE STATE OF THE PARTY OF T See A. S. Barrer

### Please Type or Print in Black Indelible ink. Assure All Coples Are Legible.

21.771.41.	1. Decedent's Neme (First, Middle		D	-113		2. Dete of De Month	eth Day	3. Time of Death
			Ray Jac	kson, Si		MARCH	14, 199	
niner						or Location of Death	4c. County	of Death
Usual Residence of Decedent  10e. State		(In yrs. lest birthde)	If Under 1 Y	BALTIMO ear   If Under 24 F		h I	9. Birthplace (State or Foreign	
	220-20-6820	1√M 2□F	70 Yrs.	Months Da	ays Hours M	Irs. 8. Date of Birt in. (Month, De 1 7	y, Year) 1929	Birthplace (State or Foreign Country)  Md
			10c. City, Town or I	ocation				10d. Inside City Limits
to	Md N/	P	Baltimor	е				1 V Yes 2 □ No
ie c	10e. Sfreet and Number			10f. Zip Cod	de		10g. Citizen of V	What Country?
alD	2903 Violet A	venue		2121	L5		USA	
Iner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U,S. 13	. Was Decedent tf Yes, specify (	of Hispanic Origin? Cuban, Mexicen, Pu	(Specify Yes or No lerto Ricen, etc.)	14. Rac Btac	e - Americen Indien, ck, White, etc.
Y FL		If Yes, Give		1  Yes 2 ♥				«Black
Q P		Year or Detes:	16c Doo	adantia Haval O				usiness/Industry
olete	(Specify only highes	t grede completed)	(Giv	edent's Usual Oc e kind of work do DO NOT use re	one during most of	working	Amoco	Oil Company
шо		College (1-4or 5+	+)	lanager			7111000	orr company
		-			18. Mother's i	Name (First, Middle,	Maiden Sumen	10)
	John Jackson		Merritt					
T						Rural Route Number		
	Verdell Ray Joh	inson-Daughte		Cator A		Baltimore		
		3 □Removal from State	20b. Place of Disp cemetery, cri	oosition (Neme o emetory or other	place)	Date	20c. Location -	Clty or Town, State
	4 Donation 5 Other (S)	ecify)	Arbutus			3-23-99	Arbutus	s, Md
	21. Signature of Fungati Servica I	icensee	1	22. Name and Ad March	F/H West			
	1/ / Jali	x // (a	un	4300	Wabash A	venue Bal	timore,	
	Immediate Ceuse (Finel disease or condition	a	SMOKE INF	MALATION				Approximete Intervel Between Onset and Death
mlne	Sequentiathy list conditions	b	Due to (or as a cons	equence of):				
Exa	if any, leeding to Immediate cause. Enter Underlying		2 10 10 00 00 00 00	,				
-	triat initiated events							
clar	Dad II Other significant conditio	a a antiferiting to startly but	and enculting in the	un do h do n no un	a shoot in Dant I	22h Did	lahasan una an	atellites to the sauce of death?
hys	Fait II, Other eighticent conditio	e writibuting to death but		23b. Did tobacco usa contributa to to				
by P								
pieted							an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
HO						194	Yes 2□No	1 ☐ Yes 2 ☐ No
					28. Place of	Death (Check only o	ne)	
0		Hospital: 1 🗵 Inpatien	t 2 ER/Outpatie	ent 3 DOA	Other: 4 Nursin	g Home 5 Resid	dence 6 Oth	ner (Specify)
		28a. Dete of tnjun (Month, Day	Year) 28b. Time Injury		Injury at Work?	28d. Describe I	now injury occur	red
catic	2 Accident Investig	ation Found:	1-99 Found:	L:40 <sup>M</sup>	1 ☐ Yes 2 🖾 No	INHALED S	MOKE IN A	HOUSE FIRE
ately filled in by the	datama	28e. Place of Injurbuilding, etc.	lice	28f. Location (Street and Number or Rural Route Number, City or Town, State) 2903 VIOLET AVENUE, BALTIMORE, MARYLAND				
	(Check only 2 Medical I	Physician: To the best of examiner: On the basis of and manner state	examination end/or t					
				29c. Llo	cense number		29d. Date signe	d (Month, Dey, Year)
edical	29b. Signature and title of certifier							
edical	29b. Signature and title of certifier	etholo		0	CME		MARCH 1	6, 1999
edical	Mayorte On	who completed cause of de	ath (Item 23a) (Type		CME		MARCH J	6, 1999
edical	Mayorte On	S. Korway	111	, Print)		timore, N		CAN WILLIAM



Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death March 16, 1995

Paath 4c County of Death Yea **Physician** John Edward Jones 9:00a.m. /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death Examiner 3706 Winterbourne Road Baltimore 5. Social Security Number If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days NAM 2□F 212-30-9942 65 Yrs Director April 19, 1933 Md. Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 'netural', or items 23s or 28s-f show the Medical Examiner must be notified at Md. n/a Baltimore 1XXes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3706 Winterbourne Road 21216 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. filed within 72 hours after 1- Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 Yes 2√No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Dept. Of Public Works Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w. Department of Health and Mental Hygieru important: if frem 27 is marked other tha any Injury or other traumatic acceptances. City of Baltimore Refrigeration Technician 17. Father's Name (First, Middle, Last) 16. Mother'a Name (First, Middle, Maiden Sumeme) Be "Jessie" Johnson unknown Jones unknown 19a. Informant's Name/Relationship (Type, Print) COUSIN 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Noelie Brown 3509 Foxcliff Court Apt. T2 Randallstown, Md. 21133 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Data 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from State Garrison Forest Veterans March 23 Owings Mills, Md. 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Septice Litempto 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part 1. Enter the disease, or complications that grussed/he deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause of such line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical HIV tant Examiner Due to (or as a consequence of) Examiner physician end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown by 24b. Were sutopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed 20 No 2 D No 1 Yes 1 Yes Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28d. Describe how injury occurred ne Hospital or Attending Pt n 24 hours after death. The Funeral Director: After the pletely filled in by the funeral 28b. Time of 28c. Injury at Work? Certification: 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only

Box 68760 certificate be P.0. Records, Division of Vital

Baltlmore, Maryland 21215-0020

State Registrar

**DHMH 16 Rev 6/95** 

30. Nama end address of person who completed cause of death (Item 23a) (Type, Print) C. Zarzuela spok 31. Date filed (Month, Dey, Year) MAR 2 2 1999

29b. Signature and title of certifier

Zarguel MS

323 32 Registrer's Signature

St. Calvert

29c. License number

08549

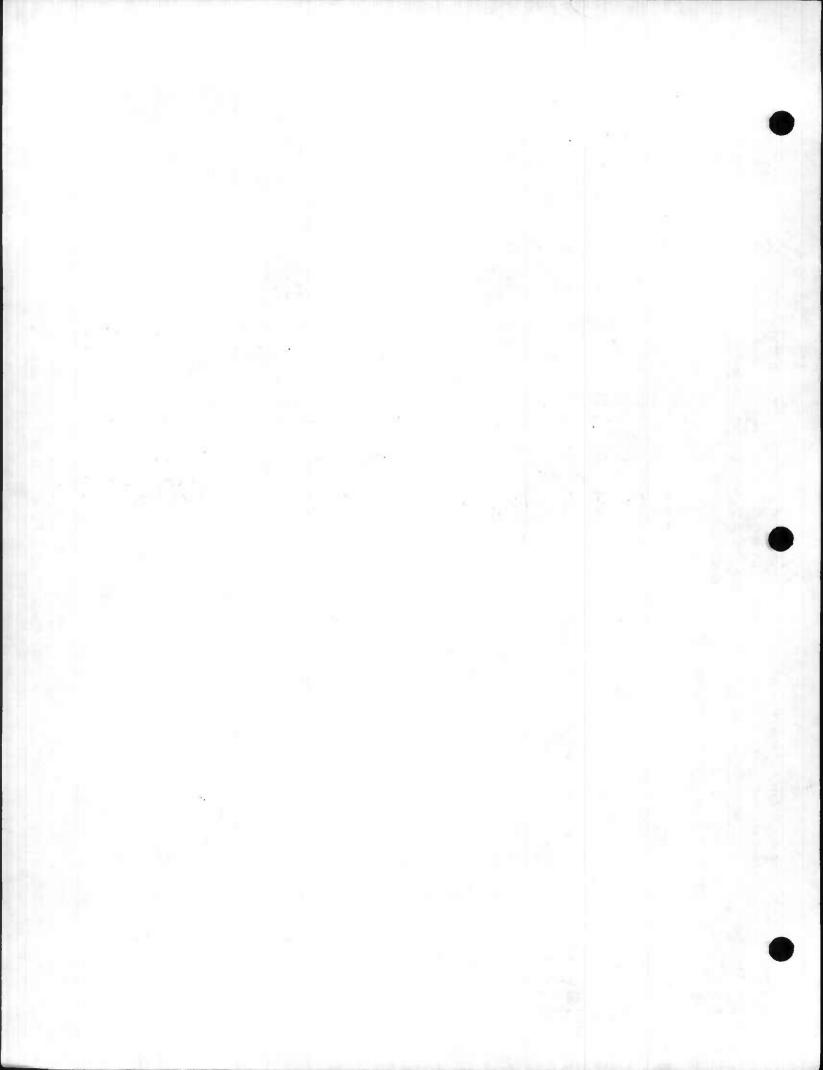
Battimore

29d. Date signed (Month, Day, Year)

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17 95

MB

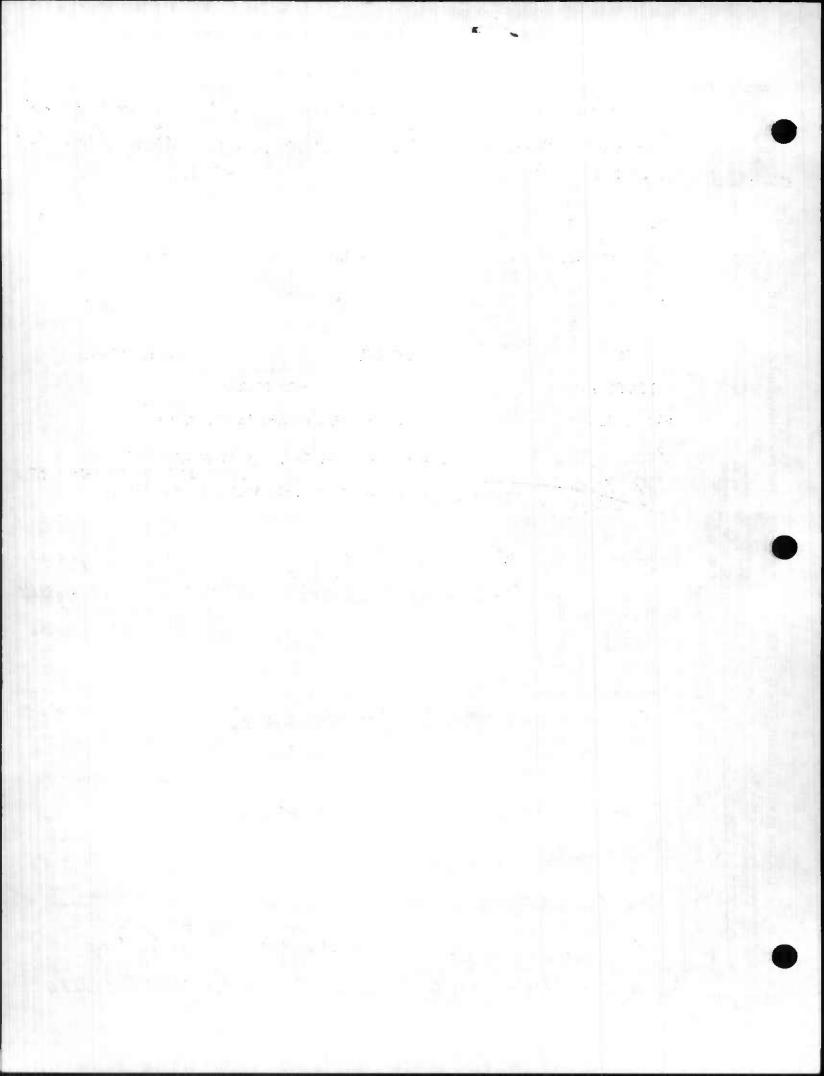


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month 03 **Physician** Edward 0445 1999 Son /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. Gounty of Deeth Examiner Vursing / 12 Age (In yrs. lest birthday) Ke thnapolis
If Under 24 Hrs. 8. Date Annapolis
5. Sociel Security Number runde D 8. Date of Birth (Month, Dey, Y 5-26-29 Birthpleca (Stete or Foreign Country) **Funeral** 1MM 2□F Months Deys Hours Min. Mb. 213-26-8809 69 Director Usuel Residence of Decedent the Marylend 10e Stete 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or itema 23a or 28a-f show treumatic event, the Medical Examiner mant be notified at 1 ☐ Yes 2 No Director MD. AA 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1004 SPAR RD. 21403 U.S.A. by Funeral death 12. Wes Decedanf Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxicen, Puarto Rican, atc.) 14. Race - American Indian, 11. Marital Stetus Bleck, White, etc. pormit. Pages 1 and 2 should be filled within 72 hours after to permit of Health and Mentel Hygiena. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced **BLACK** Completed 16e. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede com 16b. Kind of Business/Industry de completed) College (1-4or 5+) Elementery/Secondary (0-12) EMPLOYEE NAVAL ACADEMY 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) MARY PEARSON EDWARD JOHNSON 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) JEAN M. SELMON 1004 SPAR RD. ANNAPOLIS MD. 21403 other 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stata 8 MARYLAND NATIONAL CEM. 3-24-99 BALTIMORE MD. 4 ☐ Donetion 5 ☐ Othar (Specify) At Funeral Service License ESTEP BROTHERS FUNERAL HOME PL 22. Name and Addrass of Facility CECIL A. ESTEP 1300 EUTAW PLACE BALTIMORE MD. 21217 23e. Pert1. Enter the disease, or complications that causad the death. Do not enter tha mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset end Deeth **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Examiner physician end s the bunal-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thef Initiated evants resulting in deeth) Lest Due to es e consequença of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequenca of): the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by the should be datach datach 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings evailable prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes cartificate Hospital or Attending Physician:
124 hours after deeth.
 Funeral Director: After this carific. funeral director, 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Naturel 1 Yes 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Straet and Number or Rural Routa Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) completaly filled in by 4 ☐ Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and menner steted. 29a. Certifier Medicai To the To the To the 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signatura and filla of certified 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) M chman 32. Registrar's Signeture 31. Dete filed (Aldh 19an Year) 1999 State

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 18, 1999 10:09 pm Patrick F. Jordan 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A Union Memorial Hospital If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Mooth, Day, Year) 06/03/1925 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Months 1 M 2 □ F Maryland 73 Yrs 218-12-6778 **Usual Residence of Decedent** 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? U.S.A. 4111 Idaho Avenue 21206 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 14. Raca - American Indian. Black, White, etc. White 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specifi 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Woodworker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patric F. Jordan Sr. Margaret L. Dittman 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4111 Idaho Avenue Baltimore, Maryland 21206 Mamie Jordan/Wife 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 3/22/99 Baltimore, Maryland Dulaney Valley Cemetery 4 Donation 5 Other (Specify) 22. Neme end Address of Facility 21. Signature of Femoral Service Licens John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 e or compositions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, but only an cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non Small Cell Lung Cancer 1 year disease or condition resulting in death) Due to (or as a consequence of): Due to (or as e consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 10 Yes 2 No 3 Probably 4 Unknown eumonia 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? pertensim 1 Yes 2 No 1 ☐ Yes 2 No

**Physician** /Medical Examiner Examiner physician and s the burial-transit

signed by the a

this

To the Hospital or Attanding P within 24 hours after death.

To the Funeral Director: After t

Physician/Medical

p

Completed

Medical Certification: To

**Physician** 

/Medical

Examiner

MD

Director

Funeral

à

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiena. Important: if Itam 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinar must be notified at

Saitimore, Maryland 21215-0020

Division of Vitai Records, P.O. Box 68760

Patrick Jordan

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events that initieted events resulting in death) Last

examiner?		26. Place of Deeth (Check only bile)								
1 ☐ Yes 2 No	Н	Hospital: 12 Inpatient 2	☐ ER/Outpatient	3	DOA Other: 4	☐ Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)			
2 ☐ Accident in	ending nvestigation		28b. Time of Injury	М	28c. Injury at Work? 1  Yes	2 No	28d. Describe how injury occurred			
	Could not be determined	28e. Place of Injury - Al building, etc. (Spe	home, ferm, stree cify)	et, fect	28f. Location (Street and Number or Rural Route Number. City or Town, State)					

29a. Certifie (Check only 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. Iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner steted.

29b. Signeture and title of cont

A4417643589829

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brannan

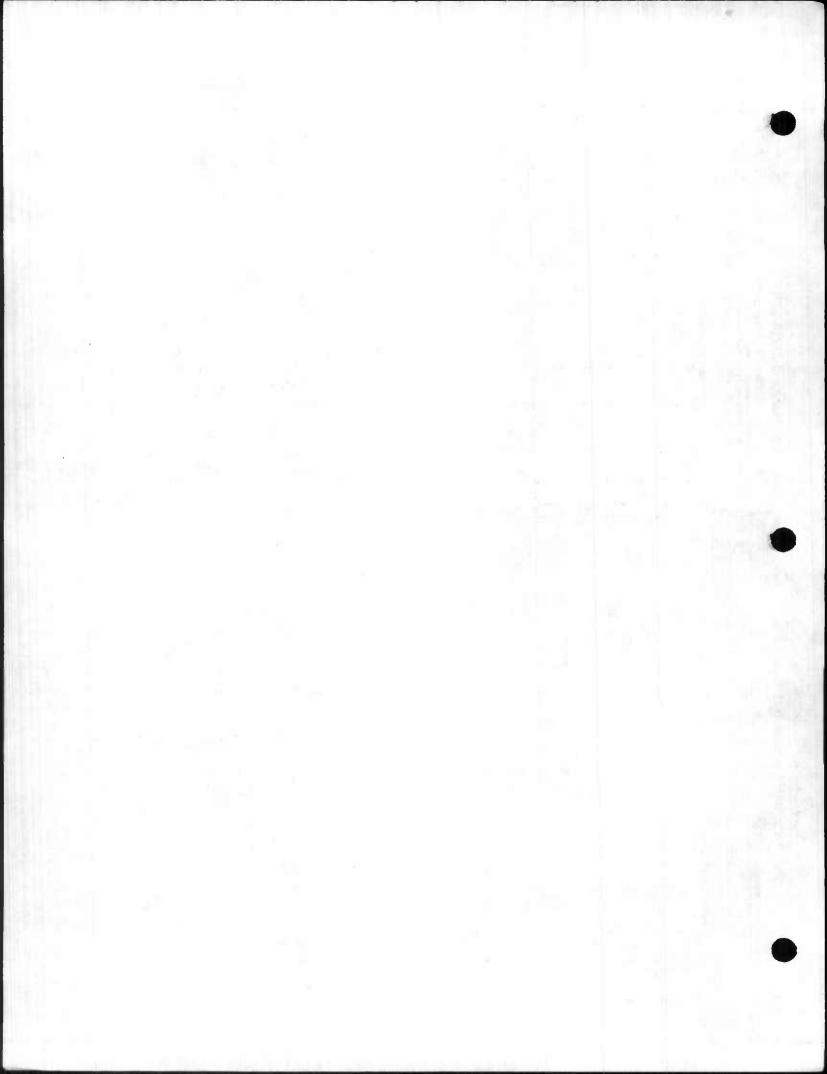
Cot

South Pack Street, Baltimore, MD 21201

State Registrar

32. Registrar's Signature

MAR 2 2 1999



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death MARCH Day 9, 1 4999 **Physician** 1:39 INGONDERG /Medical 4e Facility Name (If not institution, give street end number) Saint Joseph Medical 4c. County of Deeth Baltimore 4b. City, Town, or Location of Deeth Examiner Joseph Towson if Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) May 30 1920 9. Birthplece (State or Foreign 5. Sociel Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours 10 MM 2 F & Yrs. 220-09-2246 Director Maeyland Usuai Residence of Decedent with the Merylend 10a. State 10d. Inside City Limits Pages 1 end 2 should be filed within 72 hours efter death with the Menylen and Heatth and Mental hygiena. Intel item 27 is marked other than "natural", or frems 23a or 28a-1 show any or other traumatic avent, the Medical Enterine must be notified at 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 10 Funeral 14. Race - American Indien, 12. Wes Decadent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No IfYes, Give Yeer or Dates: WW∏ 11. Maritai Status Biack, White, etc. 1 Never Married 2 Merried Specify: White 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decadent's Usuai Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Sunpaper rowe owner Elementary/Secondary (0-12) College (1-4or 5+) YRS 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be hristopher galet (19b. Meiling Address (Street end Number or Rulel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Baltimore 2/234 mportant: If item 27 20b. Piece of Disposition (Neme of cametery, cremetory pr other place) 20a. Method of Disposition Date 20c. Location - City or Town, State March 23 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) emote 21. Signature of Funeral Servica Licanses 22. Name and Address of Fecility Chapel Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. 21234 Approximate Interval Between Onset end Death **Physician** RESPIRATORY FAILURE immediete Cause (Final diseese or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of) PNEUMONIA Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown SUBDURAL HEMATOMA þ 24b. Were eutopsy findings eveileble prior fo 24a. Was en autopsy Completed MYELODYSPLASIA completion of cause of death? certificate has b 2 No 1 ☐ Yes 20 No 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Date of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After Neturel 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation olinector: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide in 24 hour. the Funeral Directory

Division of Vital Records, P.O. Box 68760

loseph Klingenlang

FRANCIS KHOO, M. D. 7601

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

OSLER DRIVE, TOWSON, MARYLAND 21204

Cho

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) and manner stated.

29c. License number

30263

29d. Date signed (Month, Dey, Year)

03-19-99

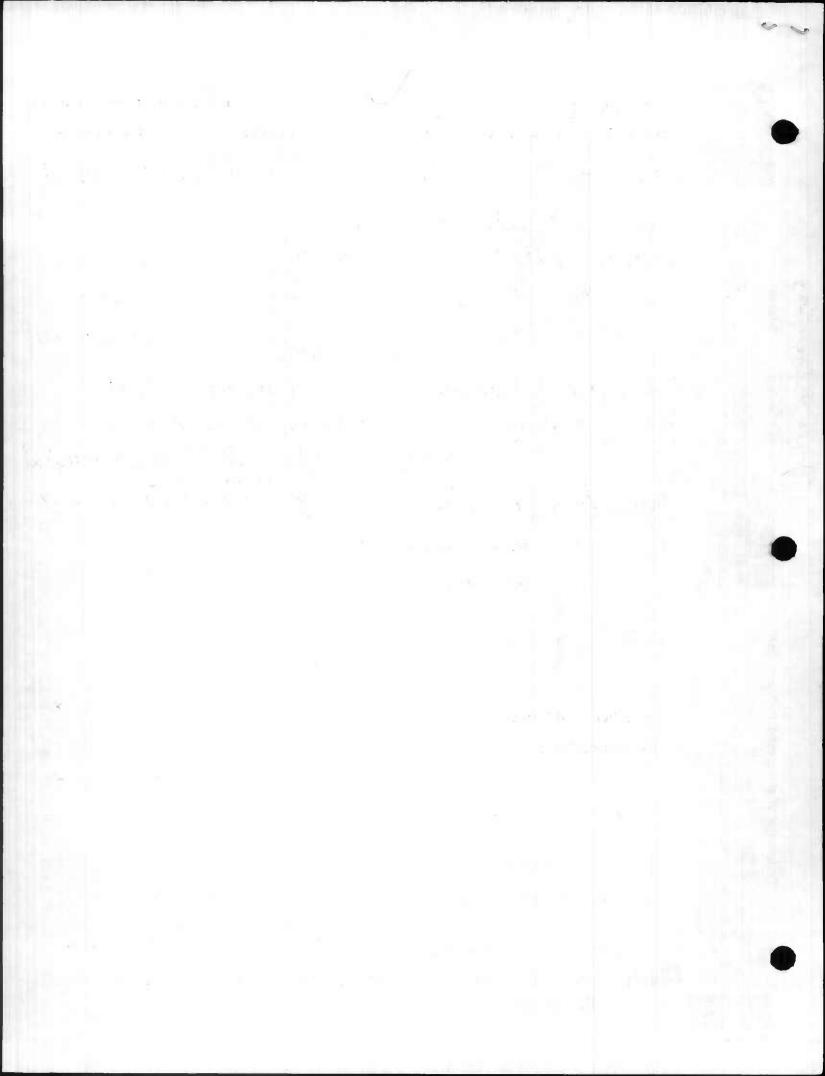
31. Date filed (Month, DMAR 2 2 199932. Registrar's Signature State Registrar

29a. Certifier

29b. Signeture end fitle of certifier

Medical

completely To the I within 2



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last, **Physician** 600 AM MARCH 20 Lois A. King /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Baltimore City Stella Maric Hospice at Mercy Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Months 1□ M 3€F Days Hours 216-40-0603 55 Yrs WV Director Aug. 17, 1943 Usual Residence of Decedent the Marylend 10d. Inside City Limits r 28a-f show 10a State 10b. County 10c. City, Town or Location N/A Baltimore City MD Nes 2 No Directo 10f. Zip Code 21230 10e. Street and Number 10g. Citizen of What Country? th end Mental Hygiene. 7 is marked other than "naturel", or items 23a or traumetic event, the Medical Examiner must be r with 1625 Patapsco Street TISA death v Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 255No If Yes, Give Yeer or Dates: 14. Race - Americen Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Peges 1 and 2 should be filed within 72 hours effer or nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Item 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes Specify: Specify: White by 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementary/Secondery (0-12) Cottege (1-4or 5+) Own Home Homemaker 8 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) John Trout Dolly Elliott 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 65, Gerrardstown WV 25420 Ralph Garlick / Son other altimore. 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) injury or permit. Pege Department of Important: If eny injury or Glen Haven Cemetery March 24,1999 Baltimore Maryland 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that couled the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Deeth **Physician** Immediate Cause (Finat disease or condition resulting in death) 3 sens /Medical Breist Concer Methotatic Examiner Due to (or es a consequence of) Examiner physician and s the burief-trans Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury Due to (or as a consequence of): Physician/Medical that initiated events resulting in death) Last Due to (or es e consequence of):

requires that the death certificate be executed 88 USB been signed by the should be detech page 2 certificete funeral director,

Division of Vital Records. P.O. Box 68760. Hospital or Attending Physician: After this 24 hours after death.

py Completed Be

Certification: To To the Hospital or within 24 hours aft To the Funeral Di completely filled in Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of ceuse of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Piece of Deeth (Check only one) 1□ Yes 22 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Specify 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Date of Injury (Month, Dey Yeer) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and menner es stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one)

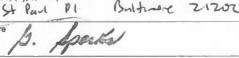
Rusebors 31. Dete filed (Month, Dey, Year) State MAR 2 2 1999 Registrar

29b. Signature end title of certifier

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30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)



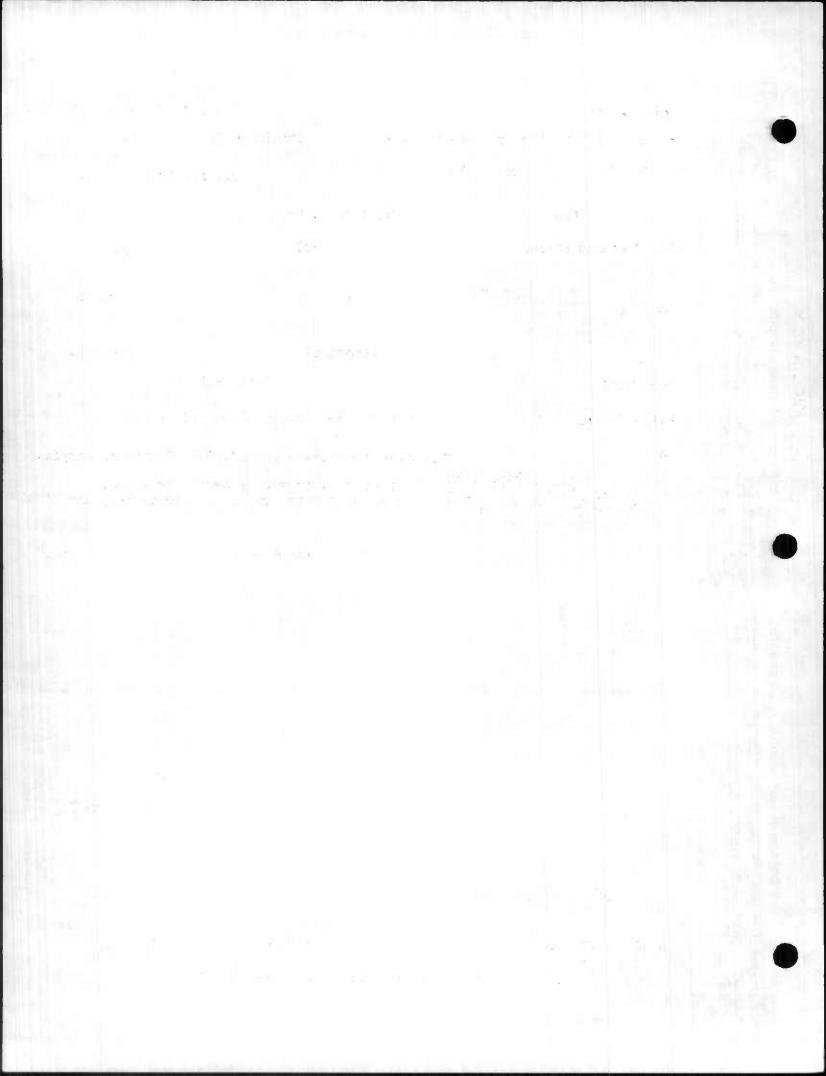


29c. License number

D40884

29d. Date signed (Month, Dey, Year)

20/4



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedant'a Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Dav Vest **Physician** MARCH FRANK WILLIAM KREBS, JR. 1999 9:22 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner BALTIMORE BALTIMORE COUNTY GILCHRIST CENTER If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) If Undar 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Yaar) **Funeral** 1 M 2 F Months Days Hours 80 Yrs. 213-05-4156 Maryland Director july 11,1918 Usual Rasidance of Decedant the Manyland 10d. Inaide City Limits 10a Stata 10b. County 10c. City, Town or Location r 28a-f ahow Maryland Baltimore City Baltimore City XX Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be USA 21214 4915 Holder Avenue Funerai 12. Was Decedenf Ever In U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Ricen, atc.) 14. Race - Amarican Indian. 11 Maritel Status Black, White, etc. 1 Yas 2 No If Yes, Giva Yaar or Datas: WW]] MYNavar Married 2 Married 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) Hygiene. Self-Employed Contractor 4 yrs. 12 yrs. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be 1 end 2 should be Heelth and Mental Marie Hanna Schwarz Frank William Krebs, Sr. 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Typa, Print) item 27 I 25 Mountain Rd. Fallston, Maryland 21047 Grason I. Krebs 20a. Mathod of Disposition 20b. Piece of Disposition (Nama of camatary, cramatory or other place) Data 20c. Location - City or Town, State Peges ortant: if i 1 Burial 2 Cramation 3 Ramoval from Stata 3-20-99 Baltimore, Maryland Parkwood Cemetery 4 Donation 5 Othar (Specify) 22. Nama and Addrass of Fecility
Lassahn Funeral Home 21. Signetura of E el Service Licensae 21236 7401 Belair Rd. Baltimore, Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Dua to (or as a consequence of) Examiner physician end the bunal-transit Sequantially list conditions, if any, laading to Immediata causa. Enter UnderlyIng Causa (Disaese or injury that initiated avants rasulting in daath) Lest Due to (or as e consaquance of): that the death certificate be execu Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): 98 esn signed by the a 23b. Did tobacco use contribute to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying course given in Part I. 3 Probably 4 Unknown 1 Yee 2 No by 24b. Wara autopsy findings available prior to completion of cause of death? should Completed 24a. Was an autopsy page 2 2 No 1 Yas 1 ☐ Yas 2 ☐ No certificate Physician: 25. Was cesa rafarrad to medical axaminar? Be 28. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatlent 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 2 1 Yas 2 No this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Tima of Certification: if or Attending P after death. Director: After t 5 Panding Invastigation Injury 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Plece of Injury - At homa, farm, straet, fectory, office building, atc. (Specify) in by 4 Homicida Hospital 24 hours a Funeral D 15 Certifying Physician: To the bast of my knowledge, deeth occurred at the time, data and place, and due to the causa(s) and mannar as etated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and mannar stated. 29a. Cartifian Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifie 29c. Licansa number Murch 18, 1999 S

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32 Registrar's Signetura

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31. Data filed (Month, Day, Year)

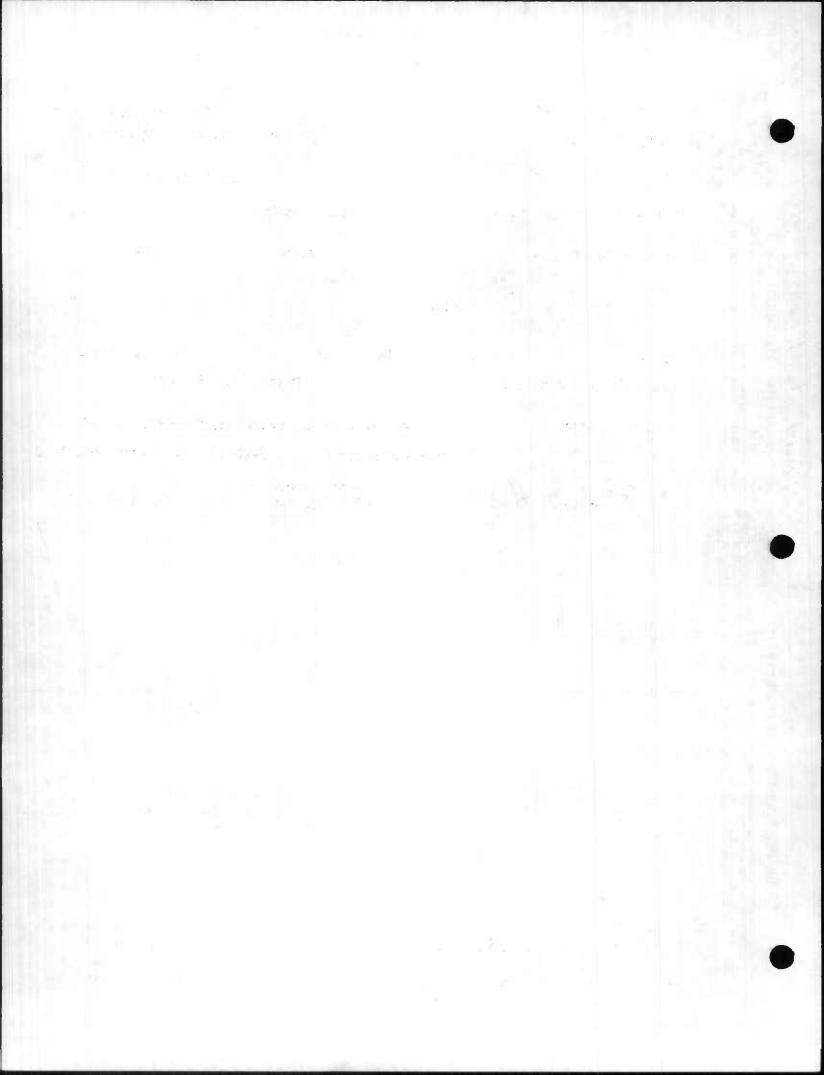
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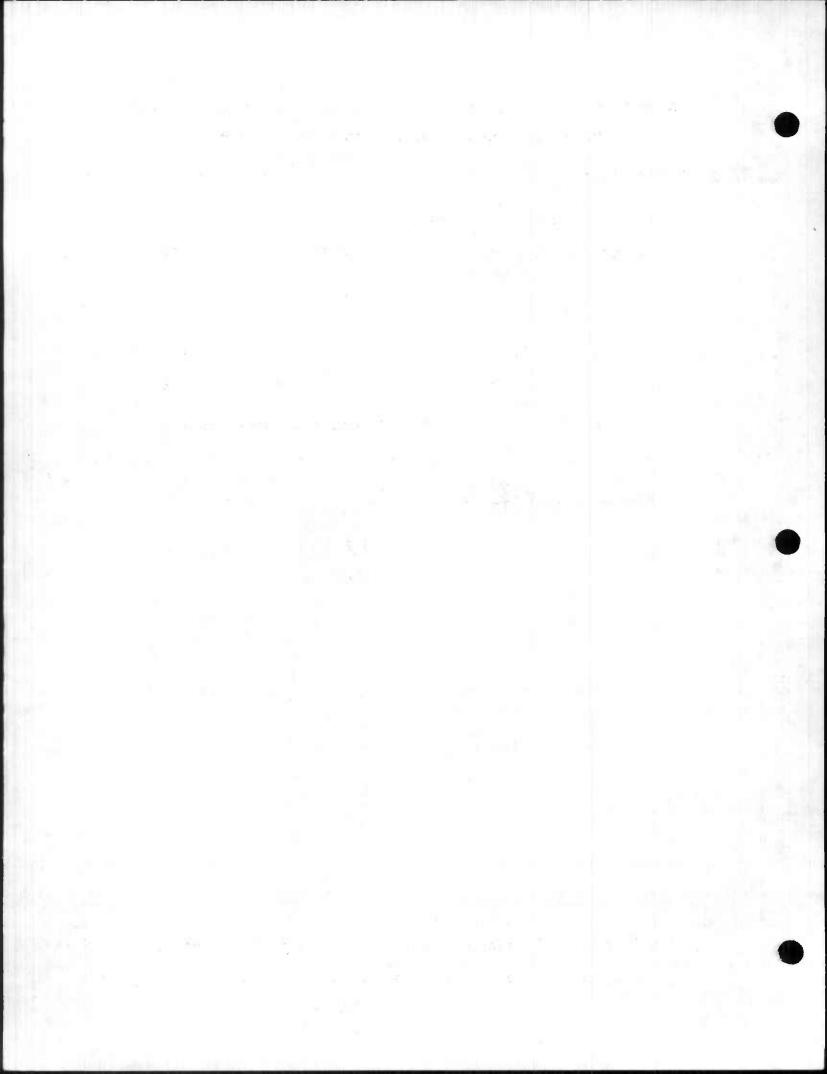
Registrar



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State of Maryland / Department of Health and Mental Hygiene 9 0 148

					Cei	tificate of	Death			Reg. No.																					
		Decedent's Neme (First, Middle						Date of Death 3. Time of De																							
Physicia /Medic		GRACIE LEWIS					Month				999	104041																			
Examin		4a. Facility Name (If not institution Lorien Fran			Reha			wn, or Loo ltin	cation of Deeth	4c. Coun	ty of Death																				
Funeral Director		5. Social Security Number  220-22-5514  Usual Residence of Decedent	6. Sex 1 □ M 212 F	7. Age (In yrs. lass 72	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth Month Day	-26	9. Birth Cou	plece (State or Foreign intry) VA																			
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72 ho	eted	15. Decedent' (Specify only highes	s Education	1	16a. Deced	ent's Usual Occup	ation	of working	10	16b. Kind of	Business/Ir	ndustry																			
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d 2 should be filed with th and Mantal Hyglene. 7 is marked other than traumatic event, the M	To Be	Anderson						8. Mother's Name (First, Middle, Marie			Oliver																				
shou and M amar umat		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	g Address (Street	and Numbe	or or Rurai	Route Numbe	r, City or Tow	n, State, Zij	p Code)																			
St 1 end of Health Rem 27 other tr				Frances Gri1  20a. Method of Disposition  12 Burlal 2 Cremation  4 Donation 5 Other (So	3 □Removal from 5	State	a of Dispose etery, crem	sition (Name of atory or other place	:е)	1	Dete	20c. Location	- City or T	D.21229 own, State nsville, M																	
permit. Pages Department of Important: If it any injury or once.	4 Donation 5 Other (Specify) Western Star Cemetery 03-23-99 Ca  21. Signature of Funeral Servica Licensee 22. Name end Address of Facility Baltimore, M.  WM.C. March FH 1101 E. North									Mar	yland 212																				
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Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)	a. Ce	re 6 ro		cer(ex	A	CC	id en			Onset end Death  W ZS																			
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D 25	9	1 Yes 2/PNo  27. Manner of Death  Solvetural 5 Pending investigation	28a. Dete o (Month		Outpatient b. Time of Injury	28c. Injury Work	4 PSL NUI	21	e 5 🗆 Reside 8d. Describe he			(y)																			
To the Hospital or Attending within 24 hours aftar death.  To the Funeral Director: After completaly filled in by tha fune	Certification:	2 Accident investiga 3 Sulcide 6 Could no 4 Homicide determin	t be 28e. Place	of Injury - At home, g, etc. (Specify)	, farm, stre			1.	8f. Location (Si City or Town	treet and Num n, State)	ber or Rura	al Route Number,																			
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To the composition		29b. Signature end title of cartifier	110-200			29c. License	number		2	9d. Date sign	ed (Month,	Day, Year)																			
		Marther	usue	lever	and	704	1573	57	1	MAR	ut	19,1999																			
A1(10)	•	30. Name and address of person w	no completed cause	of death (Hern 23)	a) (Type, P	rint) RANKFa	0	BA	amo	2	1201	(9, 1999																			
State Registra	-	31. Date filed (Month, Day, Year) MAR 2.2.10	32. Re	gistrar's Signeture	b.	Sporter	, -																								



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ne. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month er fares many 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Randallstown If Under 1 Year | If Under 24 Hrs. | 8. Dete of 1 Northwest Hospital Baltimore Co. 8. Dete of Birth (Month, Dey, Year) 11 28 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 10 M 20 F Hours Min Months Deys Yrs. V.A. 216-18-7088 93 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7410 Allmont Road U.S.A. 21244 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 ☑ Widowed 4 □ Divorced Black 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 8th grade Domestic na Home 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Edmonia Epps Richard Jones 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Julius Bacon-Son 8328 Merrymount Drive, Baltimore Md 2 oce of Disposition (Name of Dete Dete 20c. Location - City or Town, Stete 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Marial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Md National Mem. Park 3/23/99 Laurel, Md 21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility March F/H West a 4300 Wabash Ave, Baltimore Md enter the mode of dying, such as cerdiac or respiratory errest, 21215 Approximate Interval Between Onset end Deeth 23e. Pert. Enter the disease, or complications that caused the deeth. Do not enter shock, or heart failure. List only one cause on each line. immediate Cause (Final Cardian Johnshary diseese or condition resulting in deeth) Due to (or es e consequence of): 1104102 Puch muni Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or as e consequence of) 23b. Did tobacco usa contribute to the cause of death? Pert fl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evellable prior to completion of ceuse of deeth? 24e. Was en eutopsy 1□ Yes 20 No 1 T Yes 2 No 25. Wes cese referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation

Physician /Medical Examiner

that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

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Completed

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**Funeral** 

**Director** 

permit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Haaith and Mantal Hygiena. Important: If item 27 is marked other than "naturel", or itema 23s or 28s-f show eny Injury or other traumatic event, the Modical Examines man be notified.

altimore, Maryland 21215-0020

Examiner Physician/Medicai SS usa p Completed director,

physician and the burial-transit signed by tha a d be datached f cartificata has b director, paga 2 s Certification: To Aftar this funaral 24 hours after death. filled in by

complataly within 2 Registrar

or Attending Physician:

Hospital

State

edicai

2 Accident

3 ☐ Suicide

29e. Certifier

4 ☐ Homicide

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d, Date signed (Month, Day, Year) 29c. License number

29b. Signeture end title of certifier

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

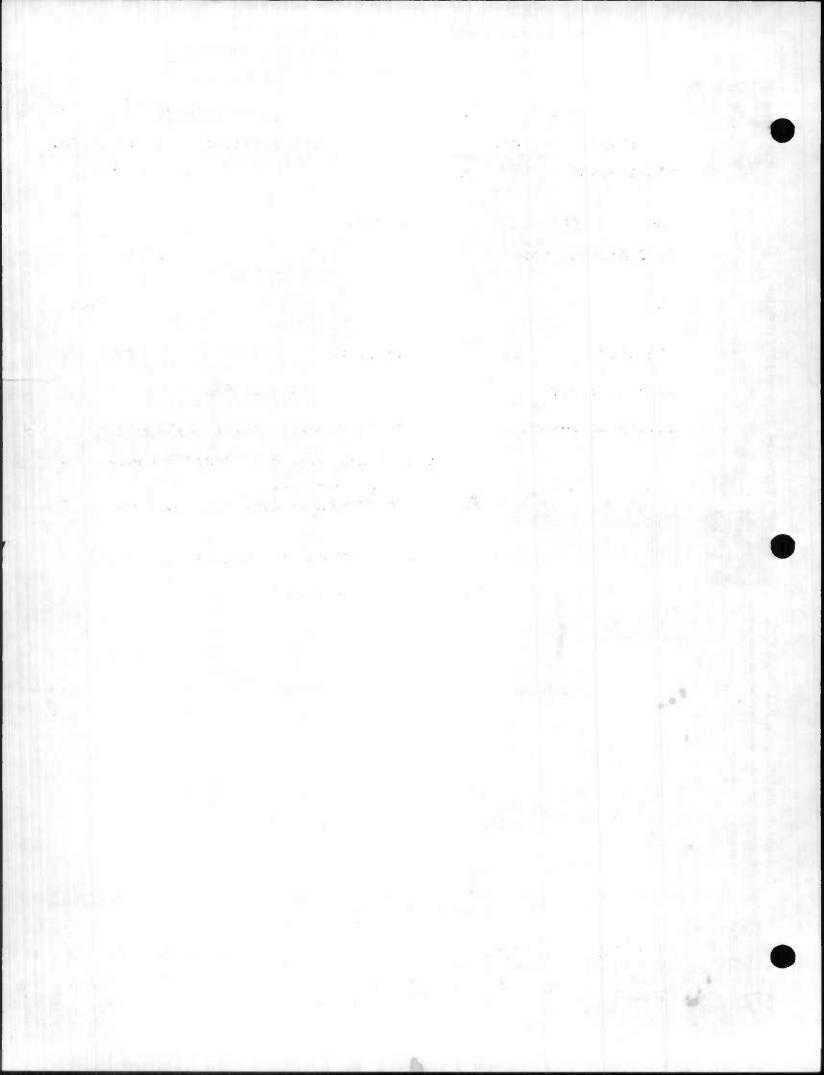
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

6 Could not be determined

31. Dete filed (Month, Day, Year) 32. Registrer's Signeture MAR 2 2 1999

Norther

28f. Location (Street end Number or Rural Route Number, City or Town, State)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dale of Death Month **Physician** March 17, Helen Letschin 1999 8:55 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Perring Parkway Nursing Home 8. Date of Birth (Month, Day, Year May 9, 1924 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 X F Months 216-18-4841 74 Director Usual Residence of Decedent the Maryland 10s State 10h Counts 10c. City, Town or Location 10d Inside City Limits tem 27 is marked other than "natural", or itema 23s or 28s-f show other treumstic event, the Macical Examinat must be notined at 1 Yes 2 No Director Baltimore Parkville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiena. other than "natural", or itema 23a 1801 Wentworth 21234 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 Yes 2 No If Yas, Give Year or Dates: 72 hours after 1 Never Married 2 Married specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygient important: If Nem 27 is marked other the any Injury or other treumation. Homemaker Own Hame 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick M. Letschin Mary Grace McGreevy 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cockeysville, MD. 21030 Robert E. Letschin (brother) 7 Firefly Circle Apt. D 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 3/19/99 Hillton Service Corp. Towson, MD. 4 ☐ Donalion 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signifure of Funeral Sarvice Licensee Dentals C. Carroll 1050 York Rd. Towson, MD. 21204 First. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final SEPSIS disease or condition rasulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury thal initialed events resulting in death) Last and Due to (or as a consequence of): Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical the Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 3 Probably 4 Unknown 1 Yes 2 No DEMEMTIA þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed been s ty POTHY ROIDISM 1 Yes 22 No 2 PNO certificata Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho edical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

DHMH 16 Rev 6/95

Registrar

31. Data filed (Month, Day, Year) MAR 2 2 1999

19215

29b. Signalure and title of certified

1 ANatural

2 Accident 3 Suicide

4 | Homicide

29a. Certifier (Check only one) 5 Pending investigation

6 Could not be



28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

Yorhern

**ORIGINAL** 

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

arkway Balhunae un 21214

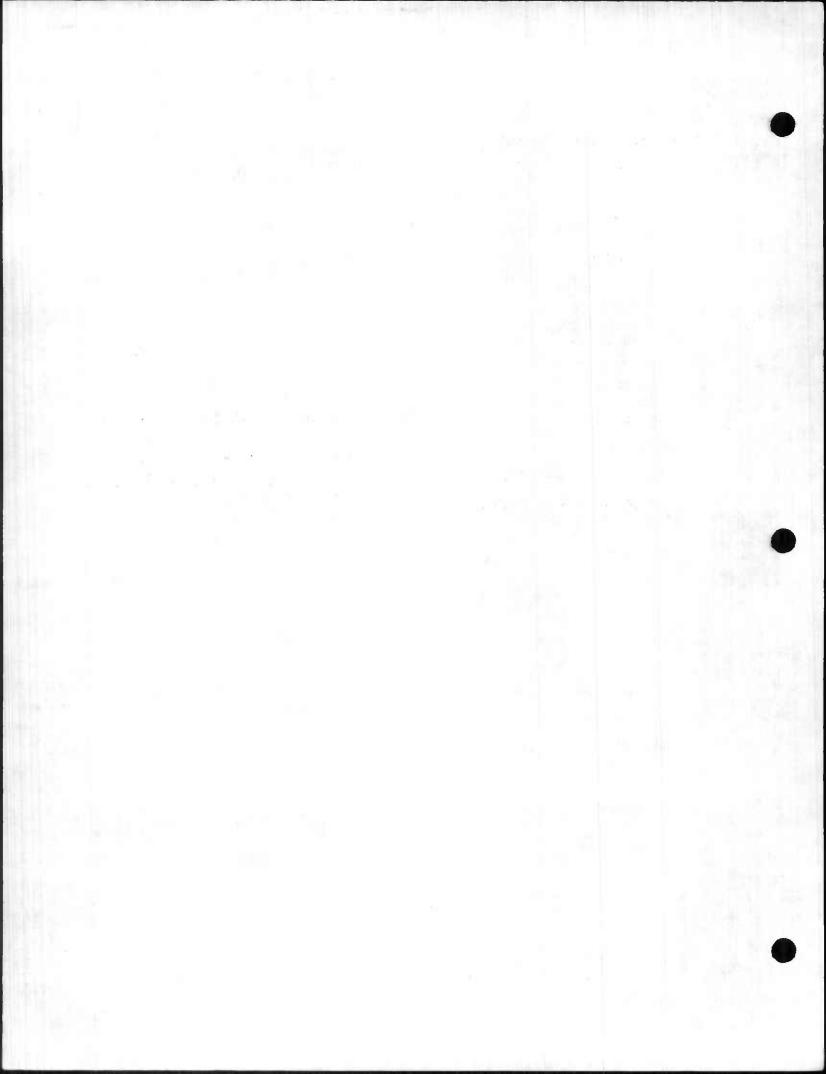
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to tha cause(s) and manner as stated.

29c. License number

1 Yes 2 No

March 18, 1999



## Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH **Physician** 1 999 10:20 PM Mary P. Leiter /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) Examiner Saint Joseph Medical Baltimore Center Towson 8. Date of Birth (Month, Day, Year) 11-28-1914 If Under 1 Year 9. Birthplace (State or Foreign 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Maryland 1□M 2□F Yrs 84 052-14-4956 **Director** Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Timonium Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumstic event, the Medical Examiner must be r U. S. A. 21093 260 Hunters Ridge Road Funeral 14. Race - American Indian, 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Black, White, efc. 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: ğ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedant's Usual Occupation 15. Decedenf's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Municipal Employees College (1-4or 5+) Elementary/Secondary (0-12) Loan Officer Credit Union 12 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 8 h and Mental i Celeste C. Camper DeOliveisa 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 260 Hunters Ridge Road, Timonium, Maryland 21093 M Health. Mrs Sandra Levy (Friend) altimore, 20a. Mathod of Disposition 20b. Placa of Disposition (Name of cematery, cramatory or other placa) Date 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) any injury or 3-20-99 Towson. Maryland Hilltop Service Corp. 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Wallace Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the mouth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line. 1050 York Road, Towson, Md. 21204 Approximate interval Between Onset and Death **Physician** RESPIRATORY FAILURE DAYS Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Dua to (or as a consequance of): Examiner DAYS PNEUMONIA requires that the death certificate be executed ettending physician end for use es the buriel-trans Sequentially list conditions, if any, leading to Immediate causa. Entar Undarlying Causa (Disease or injury that initiated evants resulting In death) Last Dua to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS Box 68760, Physician/Medical Due to (or es e consequence of): DAYS SEFSIS P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown PERIPHERAL VASCULAR DISEASE Division of Vital Records. g 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed RENAL INSUFFICIENCY completion of cause of daath? page 2 s hes certificate 1 ☐ Yes 25 No 25. Was case rafarred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Tima of Certification: or Attending Naturai 5 Pending investigation after death. 1 ☐ Yas 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, streat, factory, offica building, etc. (Specify) filled in by 4 T Homicide Hospital 24 hours 102 Certifying Physician: To tha best of my knowledga, death occurred at tha tima, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier MD 31826 ritticum 30. Nama and addrass of person who complated cause of death (itam 23a) (Type, Print) RICHARD L. LINTHICUM, M.D.,

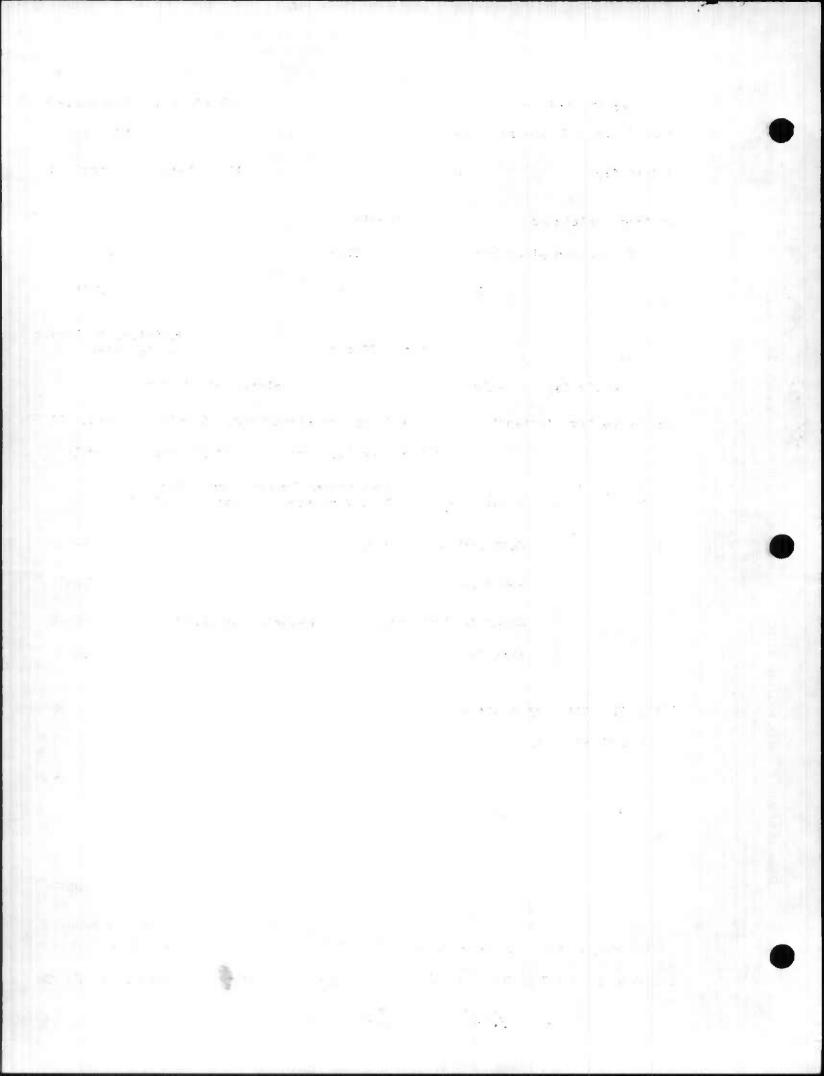
Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAR 2 2 1999

7601 OSLER DR., TOWSON, MARYLAND



**Funeral** Director

the Meryla

r than "natural", or itsma 23a or 28a-f show the Medical Examinar must be notified at al Hygiena.

hours after permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: if flem 27 is marked oth any injury or other traumatic event page.

altimore, Maryland 21215-0020

Physician Examiner

and physician a Box 68760. 克 certificate 8 for use as 9 9 ď signed to Deen certificate this d or Attending after death. I Director: Att

Completed

Be

2

Records.

Division of Vital

Certification: 24 hours a Funeral D Medical To the To the Complet Registrar

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month 18, 1999 12:00 P.M. JESSAMINE EVANGELINE LINK AKA JESSIE W. LINK MARCH 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth MONTGOMERY COUNTY 407 RUSSELL AVENUE, UNIT 714 GAITHERSBURG If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)

July 30, 1910 If Under 1 Yeer Months Days 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 28 F Mary Land 88 214-01-4026 Usual Residence of Decede 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2X No Directo Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 20877 U.S.A. 407 Russell Avenue, Unit 714 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [] Yes 2 2 No If Yes, Give Year or Dales: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: à 3 Widowed 4 □ Divorced Completed 16s. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a Medical research lab 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Monroe Whaley Lillian May Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy W. Brooks (niece) 7511 Flinty Plains Rd. Baltimore, Maryland 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery MAR.23 Baltimore, Maryland 21. Signature of Funeral Service Licepany 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, Maryland 21133 23a. Part . Enter the disease, or complication shock, or heart failure. List only one or refions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee Onset and Dec Immediate Cause (Final . My ocardial infarction Minutes disease or condition resulting in death) Due to (or as a consequence of): Examiner covonary disease 20 years arters Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? þ

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 000 1 T Yes 2 T No. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EFVOutpatient 3 ☐ DOA Othec: 4 □ Nursing Home 5 Residence 6 □ Other (Specify) 28a. Date of Injury (Month, Day Year) 26c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Homicide 29a, Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

Maybeine, 10 D 20425 3/19/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 19642 CIVS House 12d. Suite 615 A. Greene, M.D. Michael

montgomas, Village, MD 20886

31. Dete filed (Month, Day, Year) MAR 2 2 1999

25. Was case referred to medical

1□ Yes 2NNo

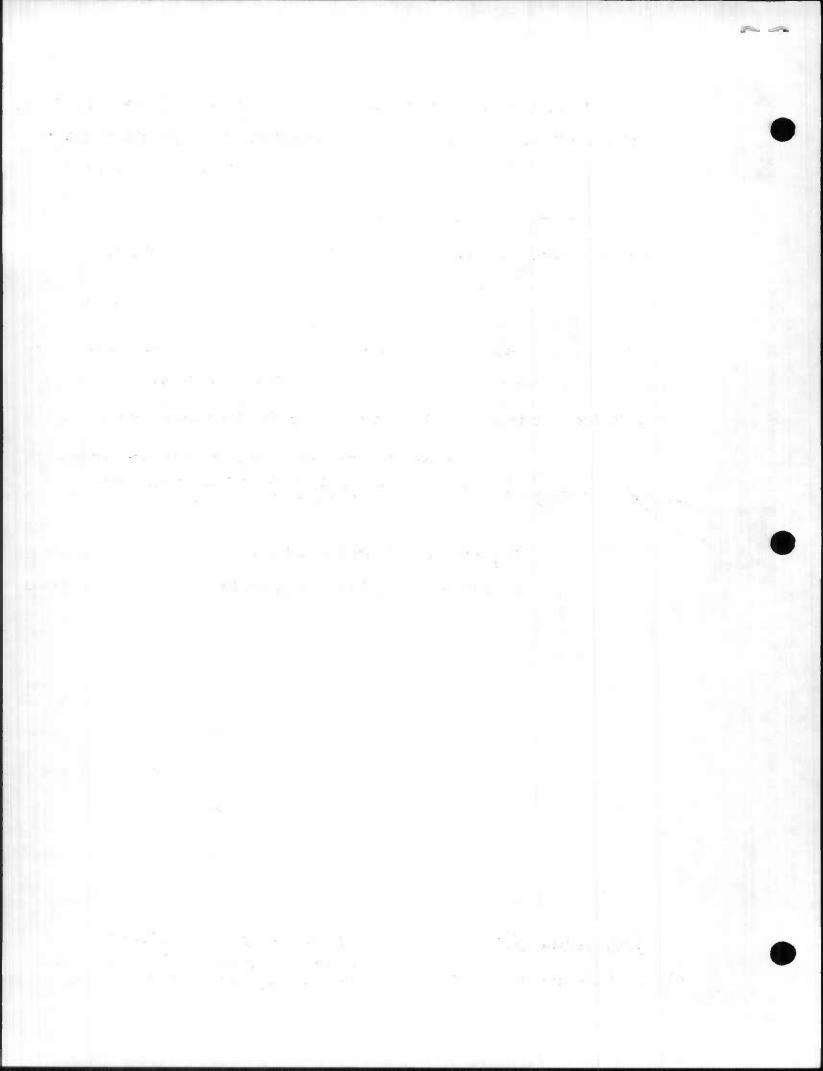
27. Manner of Death

Natural

2 Accident

3 Suicide

32. Registrar's Signature



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Smith Hook Month ALTRED 1125 mar. 15 1999 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Hospital BALTIMORE 8. Date of Birth Month, Day, If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthdey) Birthplace (State or Foreign Country) JM 2□F Months Deys Hours 215-34-8922 60 Mary low Usual Residence of Decedent 10a, Stete 10b. County 10d. Inside City Limits 10c. City. Town or Location BAIHHIRE TOYes 2 No Marylow 10e. Street and Number #206 10f. Zip Code 10g. Citizen of What Country? HEIGHTS 21218 Park USA 12. Wes Decedent Ever in U.S. Armed Forces? LOYes 2 No 1955 If Yes, Giva Yeer or Detes: 1959 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Meritel Stetus Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 tho Specify: Specify 5 6.00 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BEHLIGHER Steet Elementery/Secondary (0-12) College (1-4or 5+) STEELWORKER 12th Grade 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Williams JEAN BEVERL Anorew 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 21201 7219 Park HEIGHTI BUT 206 Bally Hove, Ma 19a. Informent's Neme/Reletionship (Type, Print) PERKER moTHER 20b. Place of Disposition (Name of cemetery, crematory or other) 20e. Mathod of Disposition Date 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from State Surays Mills Ad 4 □ Donetion 5 □ Othar (Specify) 22. Name end Address of Fecility CHATHAN-21. Signeture of Funeral Service/Licensee BAHHUM, Md 21217 Deta 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Dua to (or es a consequence 1988 Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disaase or injury that initiated evants resulting in death) Last Due to (or es a consequence of): 1990 -ailure 2en-1 Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 19 88 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 2000 1 Yes 2 ER/Outpatient 3 DOA 27. Menner of Death 1 Meturel 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident Could not be datamined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide Pleca of Injury - At homa, Ierm, street, fectory, offica building, atc. (Specify) 4 ☐ Homicide

Box 68760. Division of Vital Records, P.O. **Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

**Funeral** 

Director

7 is marked other than "natural", or hems 23s or 28a-f show traumstic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or hema 23 any injury or other traumatic event, the Modest Examples.

**Physician** 

/Medical Examiner

attending physician and for use as the burial-transit

Physician/Medical

þ

Completed

29a. Certifier (Check only one)

29b. Signature and title of certifier

Baltimore, Maryland 21215-0020

within 2 To the F

**DHMH 16 Rsv 6/95** 

24 hours after death.

Funeral Director: After t

State

Registrar

31. Dete filed (Month, Day, Year) MAR 2 2 1999

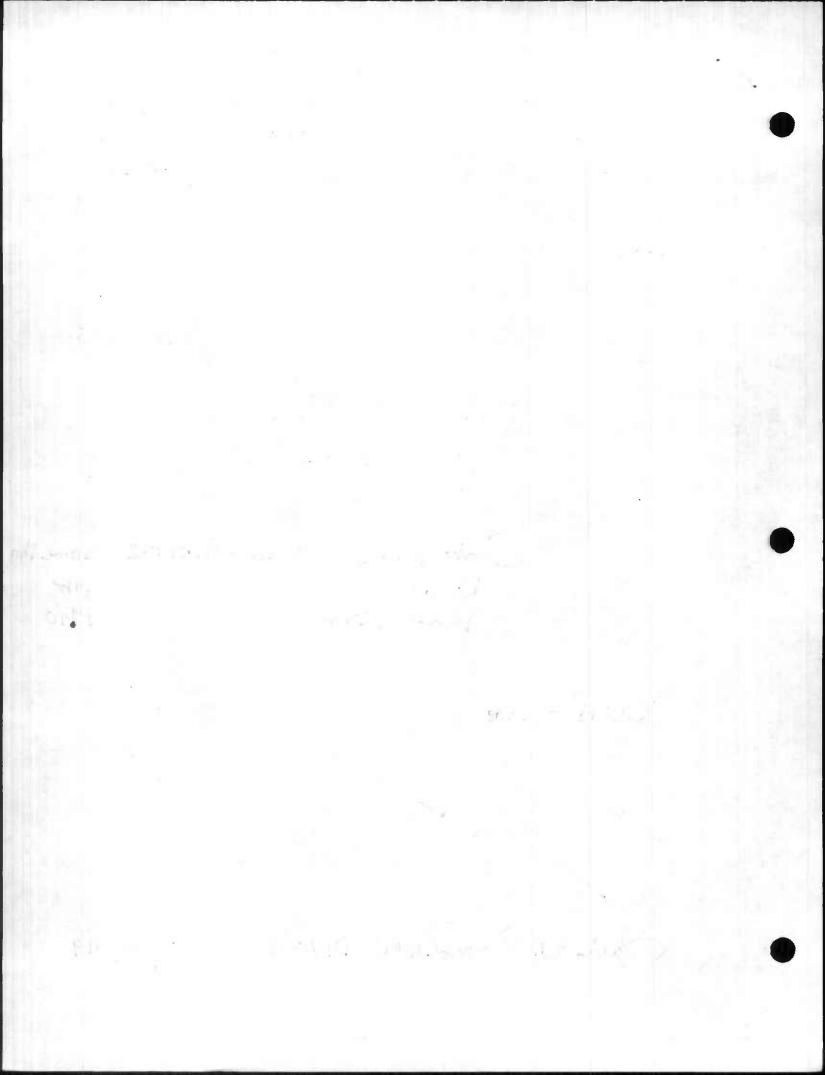
we my

29c. License number

113 Certifying Physician: To the best of my knowledga, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted. 29d. Dete signed (Month, Day, Year)

30. Neme and addrass of person who complated causa of death (Item 23a) (Type, Print)

32. Registrar's Signature



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 054 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** UTH ALBAN 1ARZULLO 16, 1999 MARCH 9:00 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours 1 M 2 F 70rx 11 111P MARYLAND Director 217 05 2461 Usual Residence of Deceden Pages 1 end 2 should be filed within 72 hours aftar death with the Maryland nent of Heatth and Mentel Hygiene. Interfer them "natural", or frems 23s or 28s-f show ary or other traumetic event, the Medical Evan met the notified at 10a. State 10b. County 10c. City. Town or Location 10d. inside City Limits 1 Yes 2 □ No Director DALTIMORE MARYLAND 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? TZAS U.S.A. 111 AVE 21212 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: WHITS p 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) RATIONAL Elementery/Secondary (0-12) College (1-4or 5+) 12 YRS WORK OFFICE LABOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be KUBY ALBAN SOPHIA 10 LLARENCE 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21212 19a. Informent's Neme/Relationship (Type, Print) insent J. Marzullo 911 EAST LAKE AV BALTIMORE MARYLADO 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) MARCH18 20c. Location - City or Town, State 21234 Burial 2 ☐ Cremation 3 ☐ Renoval from State permit. Page Department of Important: If any Injury or once. 4 Donation 5 Other (Specify) 1999 TARKVILLS 22. Name and Address of Facility 21. Signature of Euneral Service Licenses ZEissomes EVANS 8800 HARFORD 1 PARVLAGO (KOAD) ARKYILL tions that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, make an each line. 23a. Pert1. Enter the disease, or complication shock, or heart feilure. List only one man Approximate Interval Between Onset end Deeth **Physician** 2 DAYS PHEUMONIA WITH RESPIRATORY FAILURE. /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and the buriel-trensit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 80 for use es signed by the e Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE p 24b. Were autopsy findings available prior to completion of cause of death? should Completed 24a. Was an autopsy performed? is certificate has to director, page 2 s 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physician: Be 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1. Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No Certification: To this funeral 28a. Date of Injury (Month, Dey Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturai 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident eftar deati 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homloide 24 hours eftar Funeral Dire letaly filled in b 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end manner as stated. Medical To the Hosp within 24 hor To the Fune completaly fi (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number D19508 natividad D. de Lean, m. D. march 16,1999 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)
NATIVIDAD D. DELEON, M.D. 76Ø1 OSLER DRIVE, TOWSON, MARYLAND 212Ø4

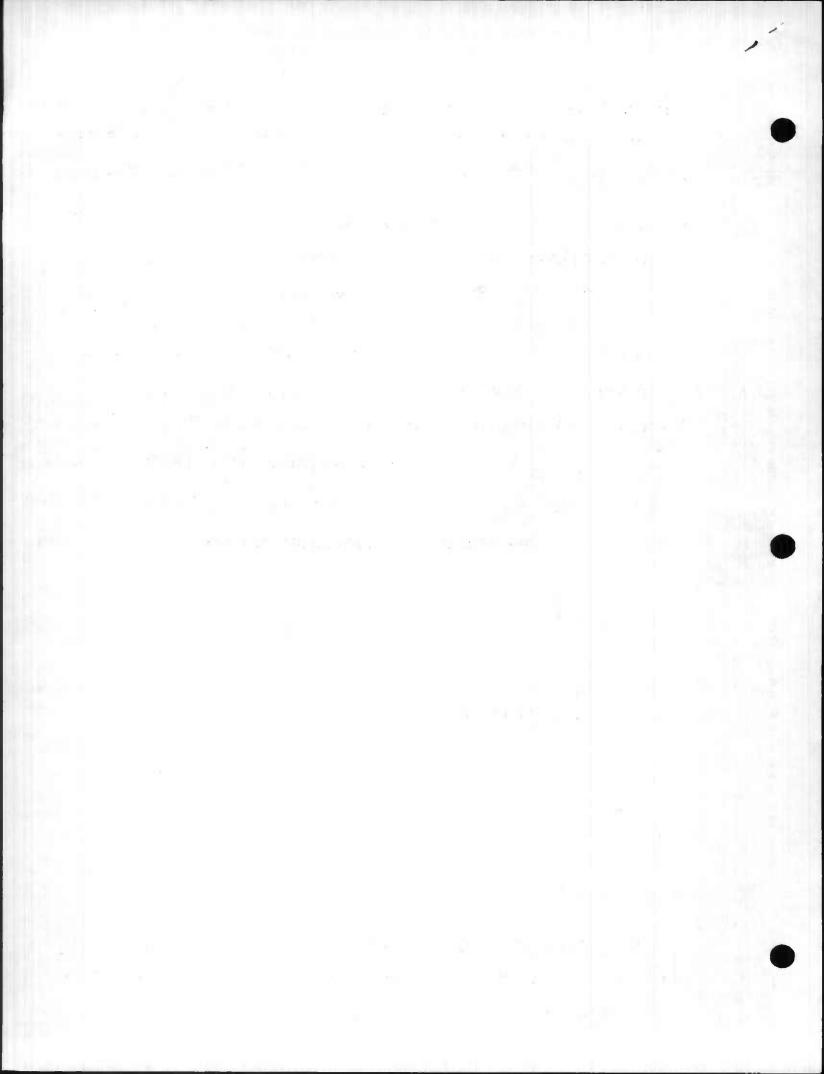
DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Yeer) MAR 2 2 1999 32. Registrar's Signature

OGR No.



### Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1 Decedent's Neme (First Middle Last) **Physician** 5:20AM March R. MONATH DOROTHY /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) Examiner Baltimore Hospital Center FranklinSquare Kosedale If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) 5. Sociel Sacurity Number 6. Sex 10 M 20 F Months Days 66 Director 212 - 32 - 843 Usuel Residence of Deceder JUNE 16, 1931 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo PARKVILLE MD. BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21234 2902 AVE Funeral MANNS 12. Wes Decedant Evar in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: ò 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b Kind of Rusiness/Industry College (1-4or 5+) Elementery/Secondary (0-12) HOME 1) HOMEMAKER AT 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be L WHOT MURPHY ROSALTITA A. HARRISS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 2901 MANNS AVE. BALTHORE, MD. 21234 ace of Disposition (Name of Dete 20c. Location - City or Town, State JOHN F. MONATH 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 1 Burial 2 Cremation 3 Removel from State MARCH 19, 4 ☐ Donetion 5 ☐ Other (Specify) GARDONS OF FAITH CEMETERY 1999 ROSEDALE, MD 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 21. Signature of Funeral Serges Licenses 8800 HARFORD RD. PARKUILE, MO. Part LEnter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete fntervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting In deeth) · Anoxic Encephalopath Examiner Acute Myocardial Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In deeth) Lest Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No Hypertension 3 Probably 4 Unknown 24b. Ware eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 2 X No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicel exeminer? 1 ☐ Yes 2 No Be 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At homa, farm, streat, fectory, offica building, etc. (Specify) 4 - Homlcide Cartifying Phyeician: To the best of my knowledge, death occurred at tha time, date and piece, end due to the ceuse(s) end menner es stated. | Cartifying Phyeician: To the best of my knowledge, death occurred at tha time, date and piece, end due to the ceuse(s) and manner stated. | Cartifying Phyeician: To the best of my knowledge, death occurred at tha time, date and piece, end due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one)

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death.

the Maryland

Lonath

orothy

r 28a-f show

7 is marked other than "natural", or items 23a or traumstic event, the Medical Experient must be

1 and 2 should be filed withi Health and Mental Hygiene.

Peges 1 and 2 nent of Health a int: If item 27 le

0 Department of Important: If any injury or

physician and the buriel-trensil

USB

page 2 s

funeral director,

State Registrar

within 2 200

29b. Signatura and title of certific

29c. License number

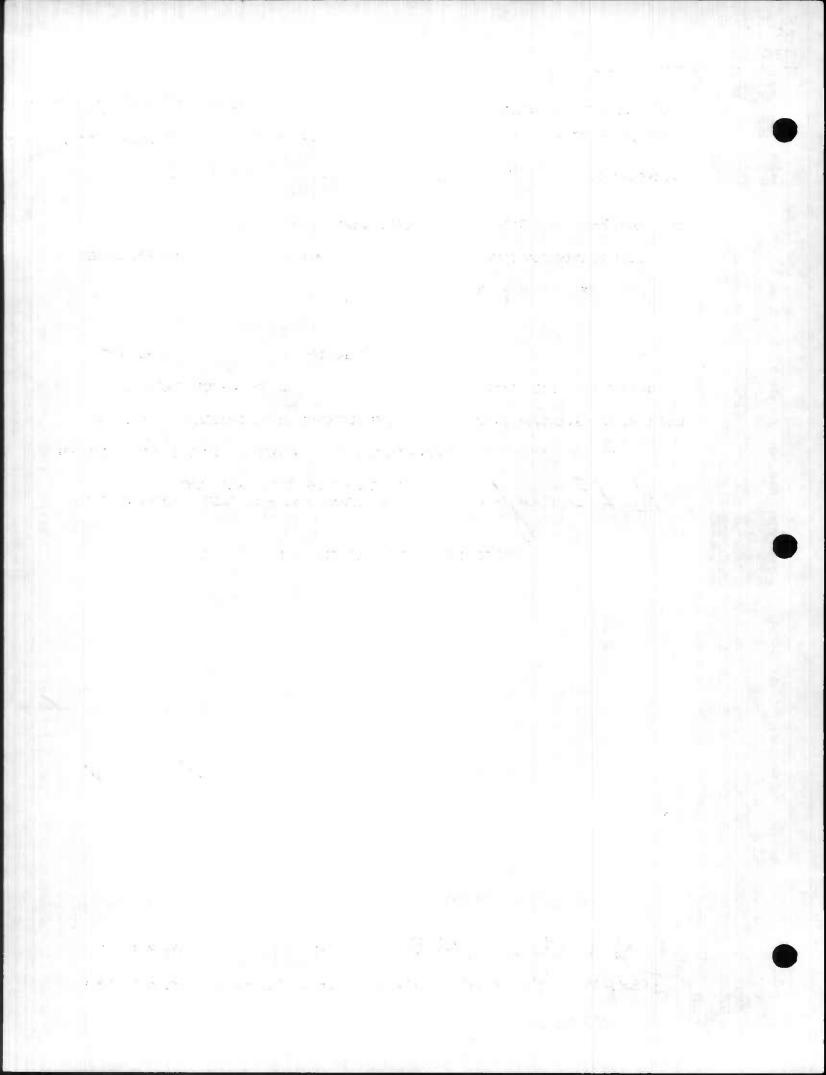
29d. Date signed (Month, Dey, Year)

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)

9000 Franklin Square Whiteford Drive Baltimore sarah 31. Date filed (Month, Day, Yaar)
MAR 2 2 1999 32. Registrer's Signeture

LUA FAMA CALL TO SEE BY THE THEOLOGY AND A SECOND OF The state of the s 34 LD-100 - 1 FORMO-23010 NOTE TO SERVER SHEET AND DEPOSITE THE PARTY OF THE PARTY

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	sician edical	DEDODALI ANNI MO CALILEY									ARCH 17, 1999 11:20 AM						
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72 hours	B	(0.1.	15. Decedent's Ed			16a. Dece	dent's Usuel Occ	cupati	ion	100	16b. Kind of B	usiness/in	dustry				
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B F G F	DUCE	KIRKLEY-RUDDICK FUNERAL HOME 421 CRAIN HWY. S.E. GLEN BURNIE										MD	21061				
Physicia /Medic Examina	al er	Immediate Cause disease or condition resulting in death)		0	RTENSIVE		ROSCLEROT		CARDIOVASO			1	Interval Between Onset and Death				
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687 flicate g physis	Medicai	Cause (Disease or that Initiated events resulting in deeth)	Injury s	c	Due to (or as a consequenca of):												
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cords requires been sign should be	Completed by									24e. Was perfor	en eutopsy med?	a	Vere eutopsy findings vallable prior to ompletion of cause f death?				
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	0	25. Was case refer	red to medical						26. Plece of Deat	h (Check only o							
of Vita Physician: this certific ral director,	ToB	examiner? 1X Yes 2	No	Hospital: 1 🔲	Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other		me 5 Resid		her (Spec	ity)				
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Division  al or Attending s effer deeth.  al Director: Afte ed in by the fune	Certification:	3 Suicide 4 Homicide	6 Could not be determined	t home, farm, st cify)	ca	28f. Location (Street and Number or Rurel Route Number, City or Town, State)											
To the Hospital or Ati within 24 hours efter of To the Funeral Direct completally filled in by	edicai	29e. Certifier (Check only one)	1 Certifying Ph	niner: On the b													
To the Within 2 To the comple	Σ	29b. Signature and	title of certifier	tane	· N	29c. License number 29d. Date signed (Month, Dey, Y  OCME MARCH 18, 1999											
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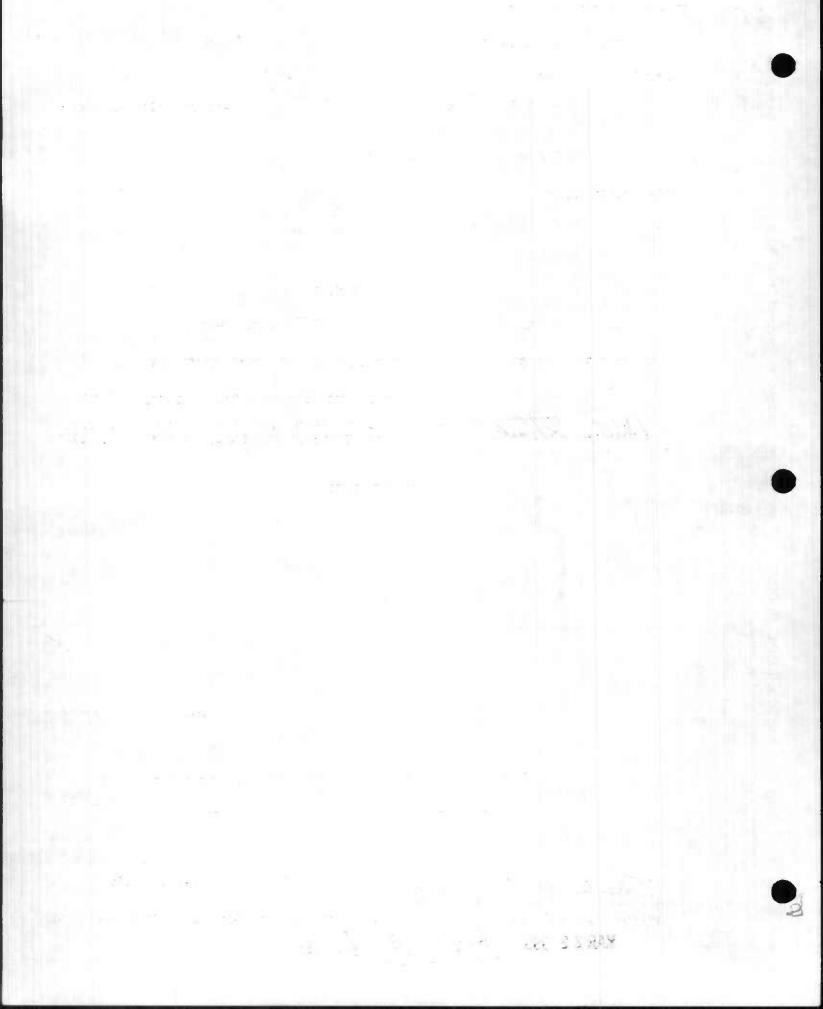


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9-1646-005 BETTY				State of	Marylar	nd / Dep	artmen	t of H	lealth a	and N	II Coples Mental Hy	giene		090!	57			
McGOWAN		TEMS: #23 PART I,  1. Decedant's Nama (First, Middl			R MEO G7	69 Ce	rtificate	e or	Deam		2. Data of De	Reg. No.		2.7	ima of Death			
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r 28	9	10e. Street and Number					10f. Zip	Coda				10g. Citizan	of What	Country?				
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d 2 Hygie Hygie ther ther ant, it		17. Fathar's Nama (First, Middla,	Last)				WAI	TRES	-	ar's Nem	na (First, Middla			SERVICE				
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lar and and sum		19a. Informant's Name/Ralations	hip (T)	rpe, Print)		19b. Meili	ng Address	(Street	and Numb	ar or Au	ral Routa Numb	er, City or To	wn, Stat	a, Zip Coda)				
os 1 en of Heal Itam 2	-	HARRY McGOWAN,  20a. Mathod of Disposition  1 □ Burial 2 ☑ Cramation  4 □ Donation 5 □ Other (S	3 🗆 F		Stata	Placa of Dispo camatary, cra	natory or of	na of thar ple	ca)		Data	20c. Locat	on - City	TAND 21502 City or Town, Stata MARYLAND				
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Bal permi Depar Impo		BRADLEY-ASHTON-MATTHEWS FUNEI 2134 WILLOW SPRING ROAD, BALL								JNERAL	HOM	E, INC	C					
Physician /Medicai Examiner	Je.	23a. Pert1. Entar tha disaasa, or shock, or haert failura. List Immadiata Causa (Final disaasa or condition resulting in daath)	compi only or	ications that cana causa on ea	N.A	RCOTIC	INTOXIC			cardiac	or raspiretory e	rrest,		Intarv	oximete al Between t and Daath			
68760 fificete be g physicla as the bur	Physician/medical Examiner	Sequentially list conditions, if any, laading to Immadiata causa. Enter Underlying Cause (Disaase or Injury that initieted evants rasulting in daath) Last		5		or as a conse												
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	by Phys	Part II. Other significant condition	ns cor	ntributing to de	ath but not ra	suiting in tha t	indanying ca	ausa gr	an in Part	l.	23b. Did tobacco usa contribut  1   Yes 2   No 3   I			Probably	4 Unknown			
aw requir	Completed					ш					24e. Was	24e. Was en eutopsy parformed?		availabla	on of causa			
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Affer fune		27. Manner of Death 1 Natural 5 Panding (Month, Day Year) 2 Accidant Invastigation 28a. Data of Injury (Month, Day Year) Found: 3-18-99 28b. Time of Injury P							P 28c. Injury at Work? 28d. Dascribe how in					injury occurred  GESTED DRUGS				
Division or To the Hospital or Attending Ph within 24 hours eiter death.  To the Funeral Director: After th completaly filled in by the funeral	Cermication	3 ☐ Suicida 6 ☐ Could datarm	not be ined		of Injury - At h g, atc. <i>(Speci</i> FOUND AT	noma, farm, st ify) HOME	reat, factory	, office			28f. Location ( City or To BALTIMO	Street and N wn, Stata)			ROAD			
Hospit 24 hour Funeri staly fills	29a. Cartifiar (Check only one)  1. Certifying Phyafcian: To the bast of my knowledge, death occurred et the time, deta and place, and due to the cartification one)  29a. Cartifiar (Check only one)  1. Certifying Phyafcian: To the bast of my knowledge, death occurred et the time, deta and place, and due to the cartification one)  29a. Cartifiar (Check only one)										cause(s) en	ause(s) end manner as stated.						
ro the or the	-	29b. Signature and titla of certifia		anu mann	ar sididU.		29c. Licansa number					29d. Data s	gnad (M	lonth, Day, Y	'aar)			
- 5 - 0		Theodie	x m	n	O.C.M.E.				MARCH 19,1999									
AH		30. Nama and address of parson				m 23e) (Type,		Penr	n Stre	eet,	Baltim	ore, M	lary]	land 2	1201			

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State 31. Data filed (Month AR 22 1999 32. Ragistrar Signeture & Sparks

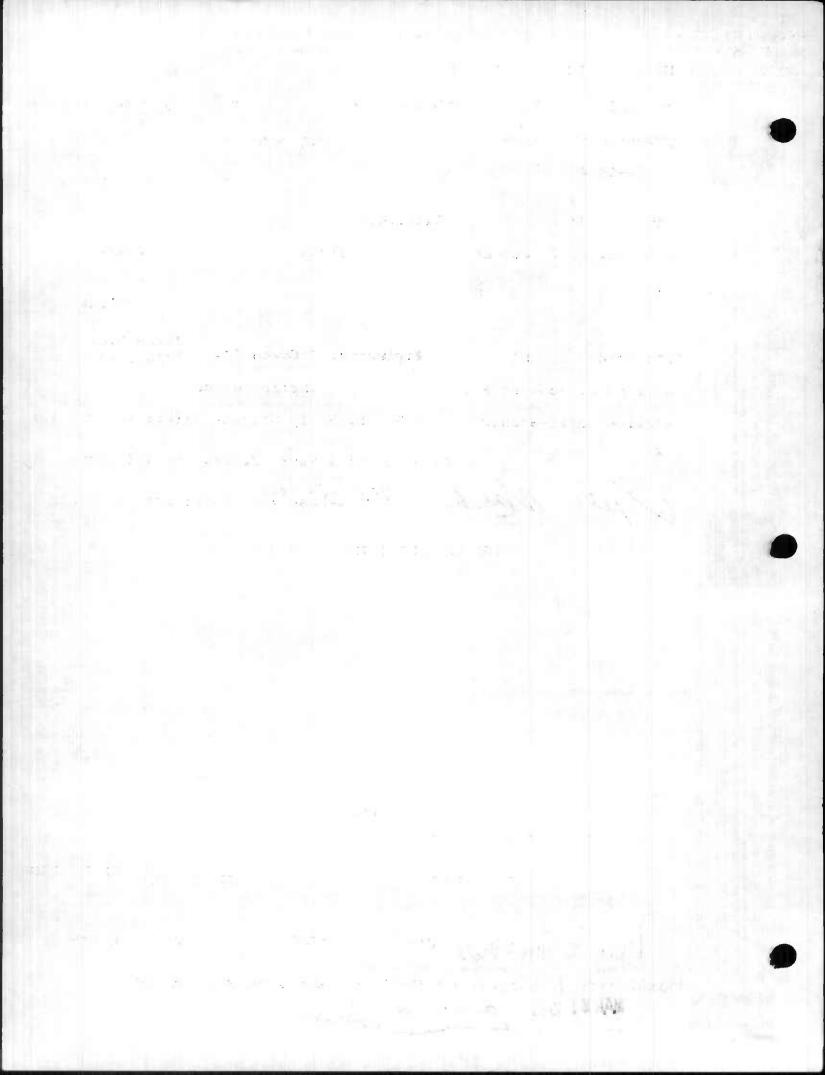


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99-1471-510 RAYMOND MCGOWEN ITEMS: #23 PART I, 27, 28A-F PER MEO G770 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** McGowen Jr. Raymond MARCH 1999 1535 PM /Medical 4b. City. Town, or Location of Death 4c. County of Deeth 4e Facility Name (If not institution, give street end number) Examiner LIBERTY MEDICAL CENTER BALTIMORE CITY If Under 1 Year If Under 24 Hrs. Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Days XXM 2 F Yrs 218-74-4844 Director 36 0.1 M.D 11 63 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County XXYes 2 No Baltimore MD NA 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 늄 r than "natural", or items 23s or the Medical Examiner must be U.S.A. 21216 2153 Mt. Holly Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 72 Value City Elementery/Secondary (0-12) College (1-4or 5+) Deliverer 12th grade Furniture 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, 88 is 1 and 2 should be fill of Health and Mental H Hem 27 is marked off Earline Johns Raymond J. McGowen Sr. 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 2153 Mt. Holly Street, Baltimore Md 21216 Earline Davis-Mother 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burlel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/22/99 Randallstown, MD King Memorial Park 22, Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 21a Plift. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, and a cardiac or respiratory errest, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ACUTE ALCOHOL INTOXICATION **Examiner** Due to (or es a consequence of) Examiner certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760. Physician/Medical Due to (or es e consequença of) 58 950 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t Records. ð 24b. Were autopsy findings aveilable prior to 24e. Wes en eutopsy performed? Completed peen completion of cause of death? The law certificate has b irector, page 2 s Division of Vital 25. Was case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ※XXXIOOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Yes 2□ No this 28a. Dete of Injury (Month, Dey Yeer) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Certification: P or Attending 1 Natural 5 Pending investigation ound: М 1 Yes 2 No death. UNKNOWN 2 Accident 3-12-99 after deatl 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, State) 3100 BRIGHTON STREET BALTIMORE, MARYLAND 3 □ Suicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 2 4 Homicide filled in FOUND: STREET Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and menner es stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piace, end due to the cause(s) and manner stated. 29a. Certifie (Check only one) To the within 2 To the 29b. Signature and title of cartified 29c. License number 29d. Date signed (Month, Day, Year) OCME MARCH 13, 1999 Whomle 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) MDSGORUM Www. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

32. Pagistrer's Signeture

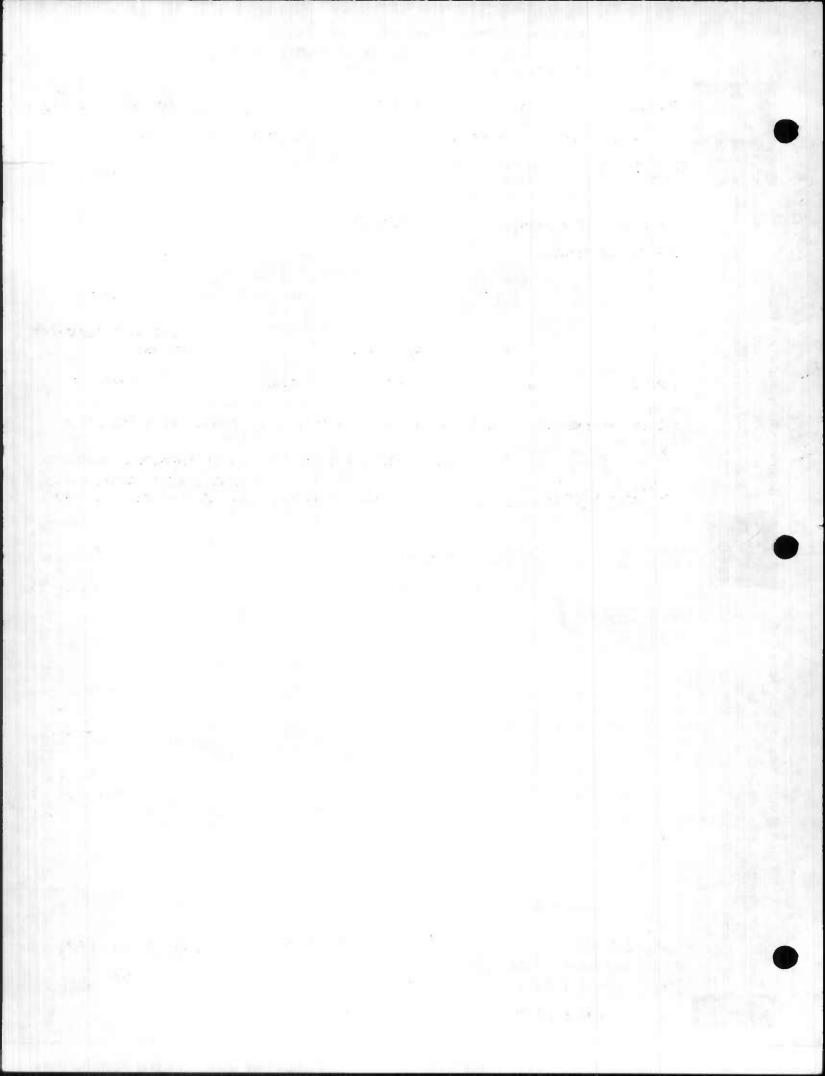


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State of Maryland / Department of Health and Mental Hygiene

Item: 5 per F.H G-769 3/25/99 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** GLORIA MAYFIELD MARCH · /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner STELLA MARIS AT MERCY HOSPICE BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 218 - 62 - 4210 218 - 42 - 6210 7. Age (In yrs. last birthday) 45 yrs 8. Dete of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ XF Days Yrs. MARYLAND **Director** JAN. 4, 1954 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahov traumatic avent, the Mexical Examinar frust be notified at 1 Yes 2 No Directo MARYLAND ANNE ARUNDEL BALTIMORE 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 629 BISCAY AVENUE 21224 U.S.A. Funeral 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Yes No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE à 3 ☐ Widowed 4 🕅 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry 2 should be filed within 72 n and Mental Hygiene. STATE FARM INSURANCE Elementary/Secondary (0-12) College (1-4or 5+) COMPANY SECRETARY 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) **JEROME** J. LANG BARBARA WAWRZYNIAK 19a. informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If them 27 BARBARA NORANBROCK (SISTER) 315 S. DREW STREET, BALTIMORE, MARYLAND 21224 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) STANISLAUS CEMETERY 3/22/99 BALTIMORE, MARYLAND 22. Name and Address of Fecility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner attanding physician and for usa as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last certificate be exe Box 68760. Physician/Medical Due to (or es e consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. datached signed by a 1 Ves 2 No 3 Probably 45 Unknown à 24b. Were autopsy findings available prior to Completed 24a. Wes an eutopsy performed? completion of cause of deeth? page 2 210 NO 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Stella MARIS AT MERCY Be Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE 1 Yes 25 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA sly 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred funeral 27. Manner of Death 28b Time of 28c. Injury at Work? Certification: After Natural 2 Accident or Attanding 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

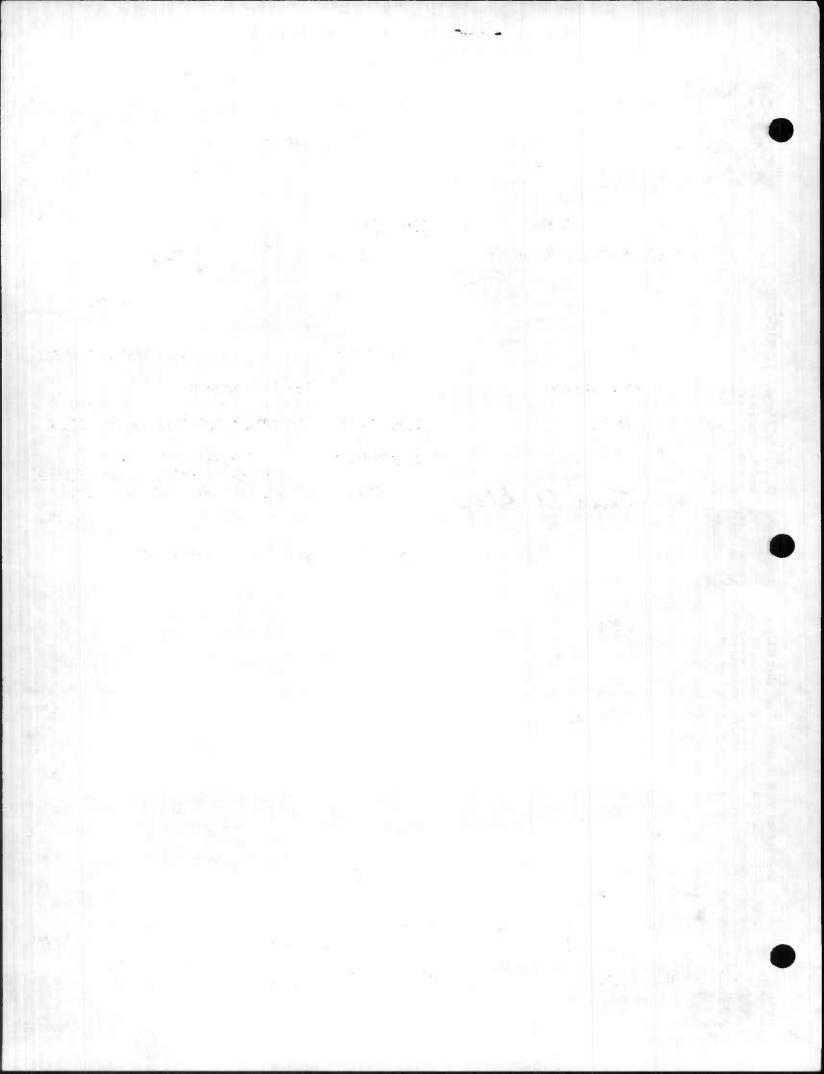
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical complataly (Check only one) To the F within 2 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 40854 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) BAltiMORE AH (10) STPAU 301 31. Date filed (Month, Dey, Year) 32. Registral's Signature MAR 2 2 1999 Registrar



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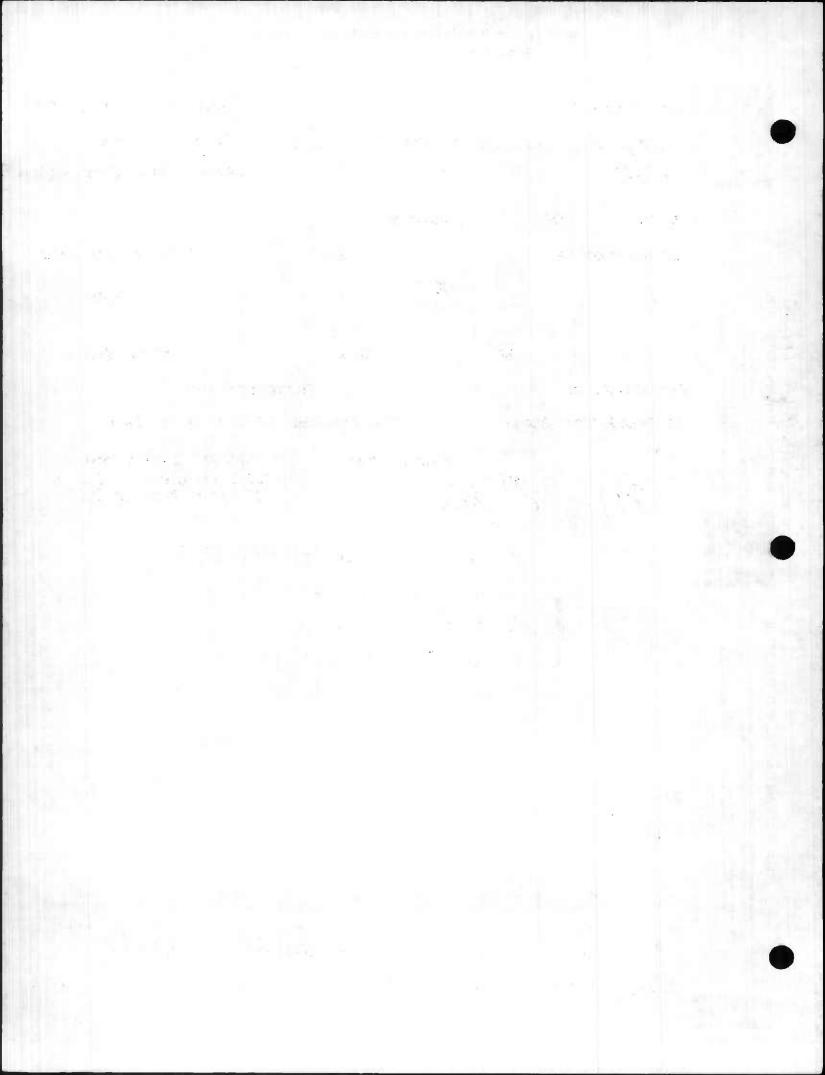
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 16TH Month **Physician** MCKINNON 11:35 Am 1999 MARCUS MARCH /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not Institution, give street end number) Examiner CENTER RANDALLSTOWN BALTIMORE. HOSPITAL NORTHWEST 7. Age (In yrs. lest birthdey) If Under 1 Year if Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1⊠M 2□F Months Deys Hours Director 218-60-2593 47 MD Usual Residence of Decedent with the Marylend r 28a-f show 10e. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No Directo RIESTERSTOWN 10f. Zip Code MD. BALTIMORE 10g. Citizen of What Country? 10e. Street end Number permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Haaith and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or is eny injury or other treumatic event, the Wed cal Examiner was be nonce. 11908 TARRAGON RD. APT#A 21136 U.S.A. Funeral 12. Was Deceden! Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 H No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DRAFTSMAN D.W. TAYLOR & ASSO. 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES MCKINNON NETTIE MCKINNON 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11908 TARRAGON RD.APT. A REISTERSTOWN MD. 21136 KAREN PALMER 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a, Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremelion 3 Removal from State KINGS MEM PARK 3-22-99 BALTIOMRE MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility ESTEP BROTHERS FUMERAL HOME P.A. 21. Signature of Funeral Service Licensee 1300 EUTAW PLACE BALTIMORE MARYLAND 21217 lec 23a. Part1. Enter the disease, or combilications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ACQUIRED SYNDROME. IMMUNE DEFECIENCY Examiner Due to (or as a consequence of) Examine physician end s the burial-transit tha death certificete be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lesl Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): attending ph signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown The law requires that SEPSIS þ 24b. Were autopsy findings eveilable prior to been sig 24a. Was an autopsy performed? Completed completion of cause of death? is certificata hes director, page 2 1 Yes 2 No 1 Yes 2 No al or Attending Physician: T s after death. It Director: After this certificat ed in by the funerel director, pa 25. Wes cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Inpatient 2 ER/Outpetlent 3 DOA 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directompletely filled in b. Kcartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 29a. Certifier edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated. (Check only THYSICIAN 29c. License number 7 4 2 7 2 3 HOUSE 29d. Dale signed (Month, Day, Year) 29b. Signature and title of certifier MARCH 16 anav 3745 FOXFOR? STREAM ROAP 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

AVVERAHALLI M HARISH: 21836 BALTI MORE 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture MAR 2 2 1999 Registrar



# Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Ferdinand J.G. Mann   Florence Sophia Moss	3	17. Fethar's Neme (Fit			CIC	IN	18. Mothe	er's Neme (	First, Middle				<b>51</b>			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month 1700 March 4b. City, Town, or Location of Deeth 4a. Fecility Neme (If not institution, 4c. County of Death Ba 10 ator en 1 nor If Under 24 Hrs. Hours Min. 7. Age (In yrs, last birthdey)
Yrs. 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year 6. Sax 9/Birthplace (State or Foreign Months 66-2668 Days 1□M 2▼F South Carolina Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No "laryland 10e. Street end Number 10f. Zlp Coda 10g. Citizan of What Country? 20 d Wes Decedant Evar in U.S. Armed Forcas? Wes Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexican, Puarto Rican, atc.) 11. Maritai Status 14. Race - Amarican Indian, Bleck, White, etc. 1 ☐ Yes 2 X No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 Yes 2 No Specify: Apolin O 3 ☐ Widowed 4 ☒ Divorced Hmer Icar 18s. Decedant's Usual Occupation
(Giva kind of work dona during most of working life. IDO NOT use ratired) 15. Decedant's Education (Spacify only highast grade completed) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) College (1-4or 5+) 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19e informant's Neme/Relationship Crope, Print daughter 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Pros 2220 Sascii Kan 20b. Place of Disposition (Nama of Comatary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta Data 1 Buriel 2 Cramation 3 Ramovei from State 123 Memoria 4 Donation 5 Othar (Specify) ar 22. Nama and Addrass of Facility seph er U a 02 Ave, 21216 North tist only one cause on each lina. Approximate Interval Batween Onset and Death Immediate Cause /Final 3 monts disease or condition rasulting in daath) Carcinomatosis Dua to (or as a consequence of): 11 Chronic In Lestinol chemone Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of) that initiated avants resulting in daath) Last Dua to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 □ Yee 200 No 3 Probably 4 Unknown plokeles mellitus COI CRAVIX apenate. Sepsis 24e. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 1 No 21 No 1 □ Yas 28. Place of Death (Check only ona) Hospital Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Dinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Netural

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To the Funeral Director: After the

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**Funeral** 

Director

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2 should be filed within 72 hours effer and Mentel Hygiene. Is marked other than "natural, or its

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**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

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25. Was casa referred to medical axaminar? 1 Yes 2 No 27. Manner of Deeth

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28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29e. Certifiar (Check only one)

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1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the causa(s) and manner stated. 29c. Licensa number 29d. Data signed (Month, Day, Year)

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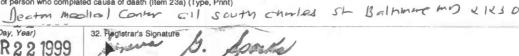
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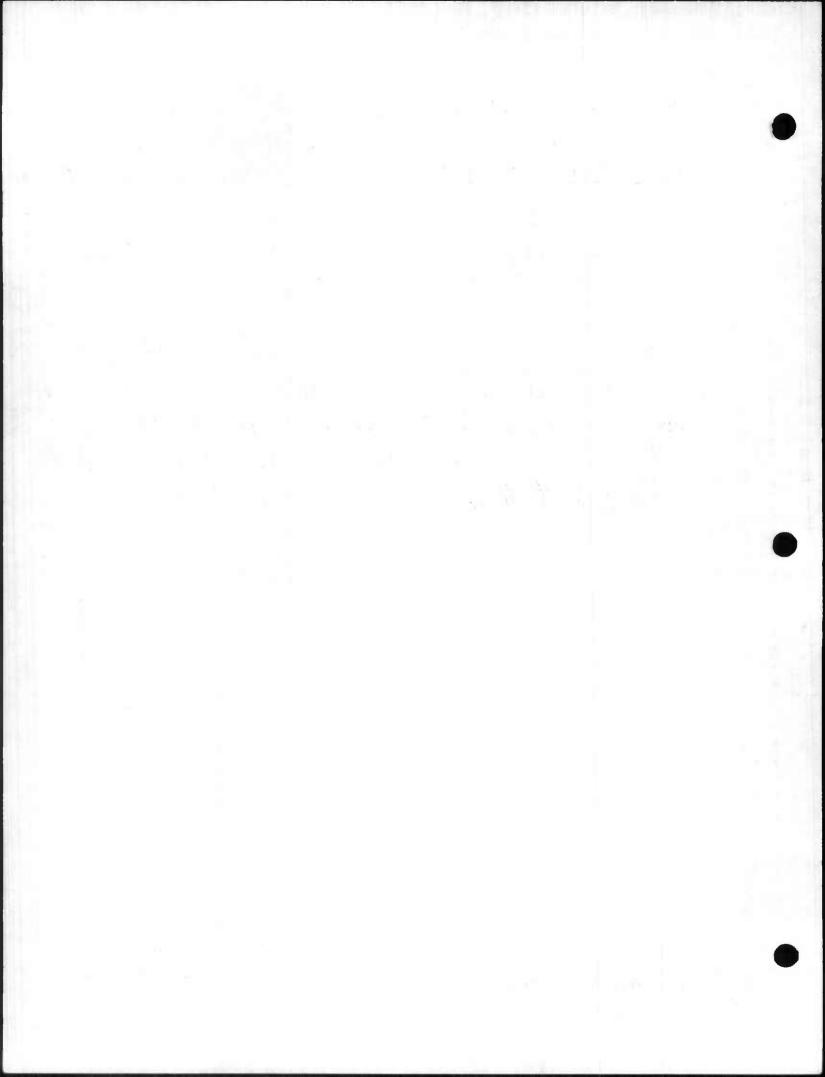
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31. Deta filed (Month, Day, Year) MAR 2 2 1999



30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print)



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Dete of Death 3. Tima of Death 1 Decedent's Nama (First Middle Last) 4b. City, Town, or Location of Daeth 4c. County of Death 4e Fecility Nama (If not institution, give street end number) 6 If Under 1 8. Dete of Birth 9. Birthplaca (Stata or Foraign . Sociel Sacurity Number 7. Aga (In yrs. last birthday) Sex 1D M 2□ F Year) Days Hours Min 7 Yrs. 32 Usual Residence of Decedant 10a. Stete 10b. County City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 260 12. Wes Decedant Evar in U.S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) American Indian. 11, Marital Status Black, Whita, atc. Yas 2 No Yas, Give Yaar or Detas: 1 Navar Marriad 2 Married Specify: White 1 Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elementery/Secondary (0-12) College (1-4or 5+) 18 Mother's Name (First, Middle, Maiden Sumama) 17. Fether's Name (First, Middla, Last) 19b. Meiling Addrass (Straat and Number or Rural Routa Number, 19a., Informant's Name/Ralationship (Type, Print), City or Town, Stata, Zip Code) 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Spacify) 22. Nama end Address of Fecility Part1. Enter tha disaese, or complications that caused tha daath. Do not anter tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one causa on aech line. Approximeta Intervel Between Onset end Death Immediate Cause (Final disaesa or condition resulting in daath) Dua to (or as a consequence of): Dua to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 | Yes 2 | No 24b. Ware autopsy findings aveilable prior to complation of cause of death? 24a. Was an autopsy performad? 1 ☐ Yas 2 ☐ No 25. Was casa raferred to medical axaminar? 26. Placa of Daath (Check only one) Hospital: Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 5 ☐ Mesidance 8 ☐ Other (Specify)

Physician /Medical **Examiner** 

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Division of Vital Records, P.O. Box 68760,

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7 is marked other than "natural", or frams 23s or 28s-f show traumstic event, the Medical Examiner must be notified at

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nt of Health it if item 27 is

Baltimore, Maryland 21215-0020

Physician/Medical Examiner ettending physician end for use as the buriel-transit Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Causa (Disaasa or injury that initieted events rasulting in daath) Last

Part II. Other significant conditions contributing to death but not resulting in tha underlying causa givan in Part I.

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28e. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Spacify)

28c. Injury at Work? 1 ☐ Yas

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28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)

28d. Describe how injury occurred

29a. Certifier (Check only the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cegal

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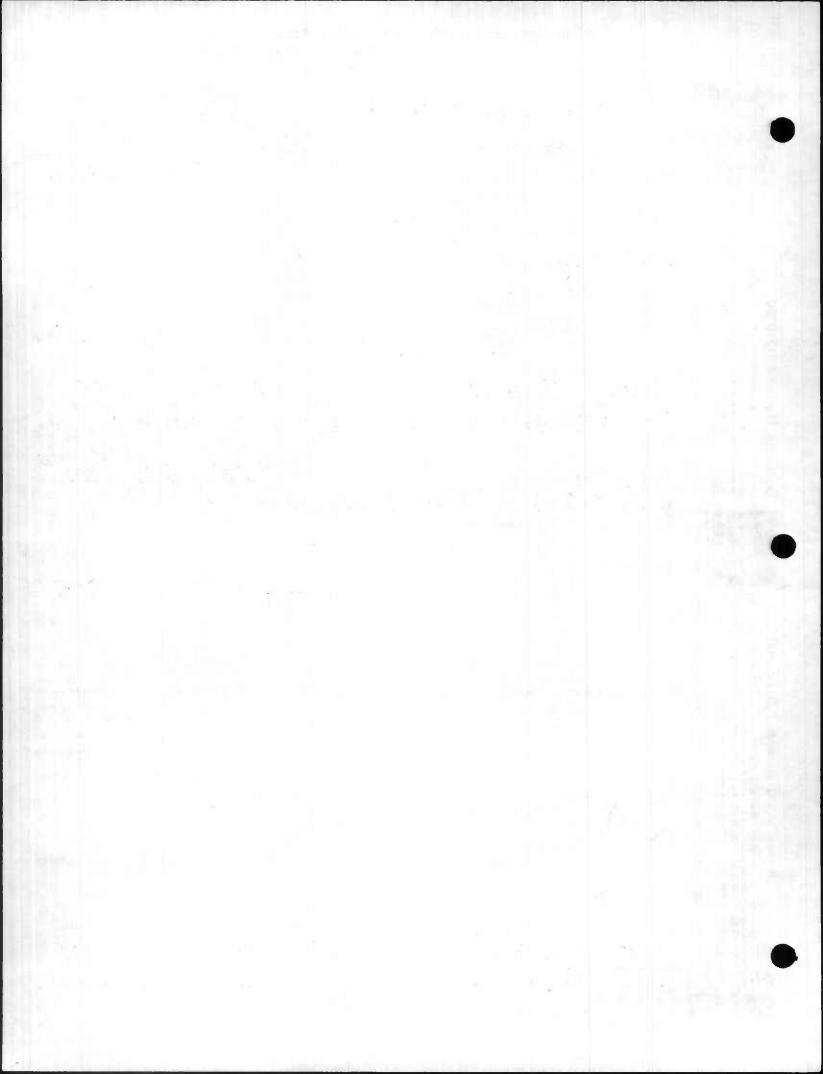
29d. Date signed (Month, Day, Year)

led cause of deeth (Item 23a) (Type, Print)

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State Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. rjaState of Maryland / Department of Health and Mental Hygiene Item 10e Per FH FilmG769 3-23-99 ITEM: #7 PER F.H. G769 3-22-99 WR Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** PROVENZA Sr. 04:00AM 99 03 OSEPH /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE OF MARYLAND UNIVERSITY | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9-29-13 | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | (Month, Day, Yeşr) | Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F 85 Yrs. 220-07-204 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Manyland Department of Health and Mental hygiene. Important: if Item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, in a Medical Examination and injury or other traumatic event, in a Medical Examination and injury or other traumatic event, in a Medical Examination and injury or other traumatic event, in a Medical Examination and injury or other traumatic event, in a Medical Examination and injury or other traumatic event, in a Medical Examination and injury or other traumatic event, in a Medical Examination and injury or other traumatic events. 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Yes 2 No BALTIMORE MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Andre ANDREW STREET 21230 STATES UNITED Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 🛠 😾 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shipping LONG SHOREMAN 8 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be Louciano Provenza Rosina Tamburo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph S. Provenza, Jr. / Son 1357 Andre Street, Baltimore Maryland 21230 20b. Place of Disposition (Name of cametery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 ☐ Cremation 3 ☐ Removel from State Glen Haven memorial park March 23, 1999 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee Victor P. Doda, Jr. 22 Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 who death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that cach shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) BACTEREMIA Examiner Due to (or as a consequenca of): Examiner OSTEDMYEUTIS physician end the bunal-transit that the death certificete be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting In death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, PERIPHERAL VASCULAR DISEASE Physician/Medicai Due to (or as a consequence of): ettending pl DIABETES MEZLITUS signed by the e 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yae 2 No 3 Probably 4 ☐ Unknown þ 24b. Were eutopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? page 2 : has 1 ☐ Yes 2 ☐ No cartificata Hospital or Attending Physician: 24 hours efter death. Funeral Director: Aftar this cartific director, 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient Certification: To 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Naturel Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 T Homicide 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. within 24 hou To the Fune completely fil Medical

29c. License number

of death (Item 23a) (Type, Print)

32. Registil

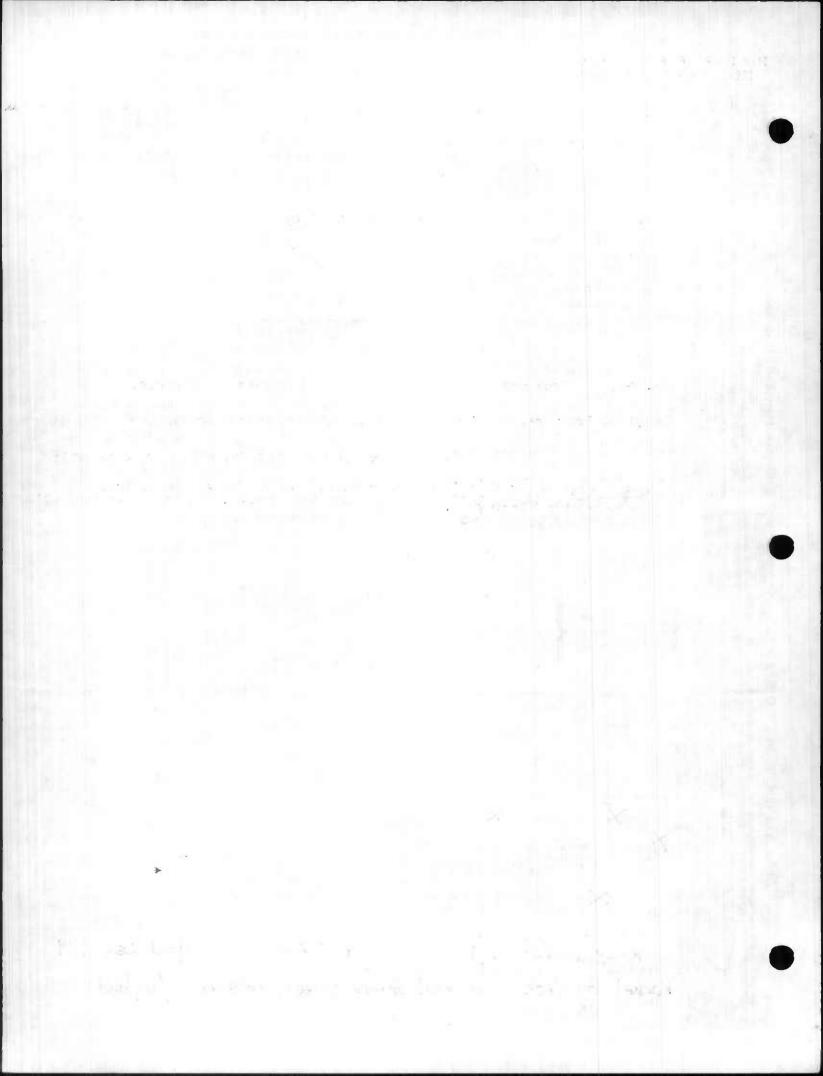
P10229

Greens Street, Baltimore, Maryland

29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of cartifier



Examiner Division of Vital Records, P.O. Box 68760,

**Funeral** 

Director

tem 27 is marked other than "naturs!", or itema 23a or 28a-f show other traumatic event, the Mexical Experiment must be insuffed at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. I important: if feen 27 is marked other than "natural", or her any Injury or other traumatic event.

**Physician** /Medical

> and physician as the burial

> been signed by should be detac

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific

State Registrar

22 31. Date tiled (Month, Day, Year) MAR 22 1999

29b. Signature and fittle #f cartifier

Greene

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) South

MD

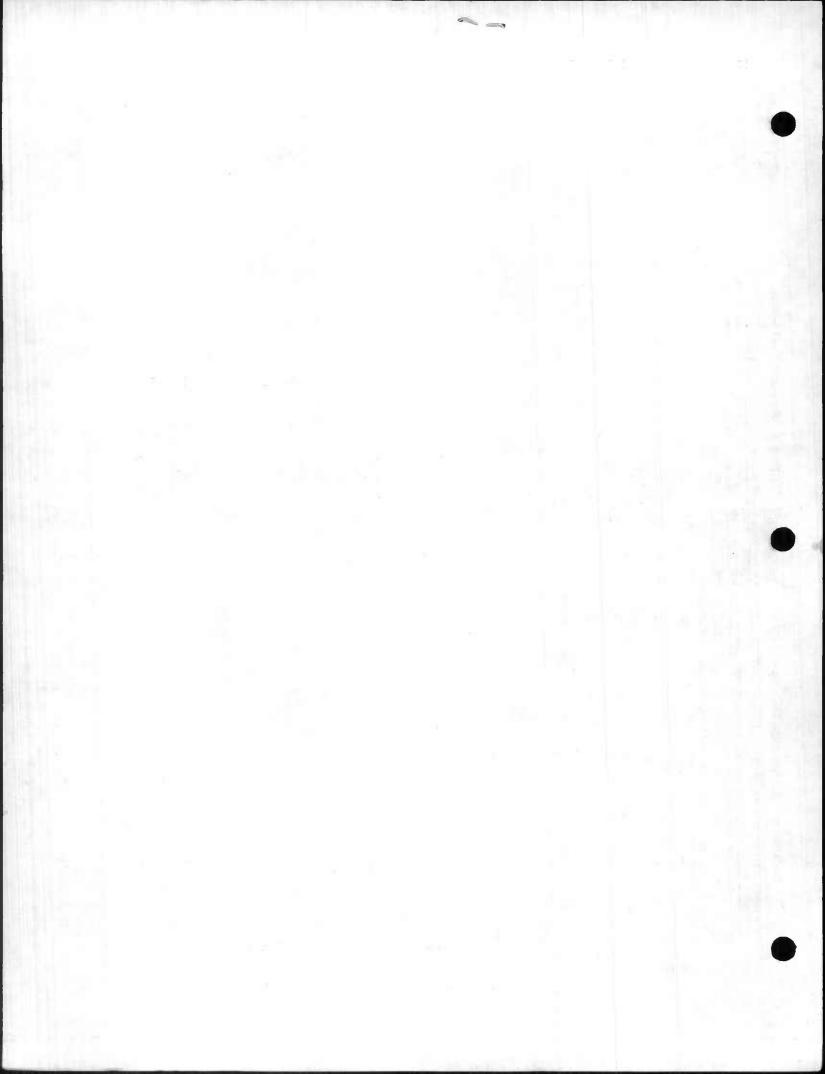
32. Registrer's Signature

Street

29c. License number

29d. Date signed (Month, Day, Year)

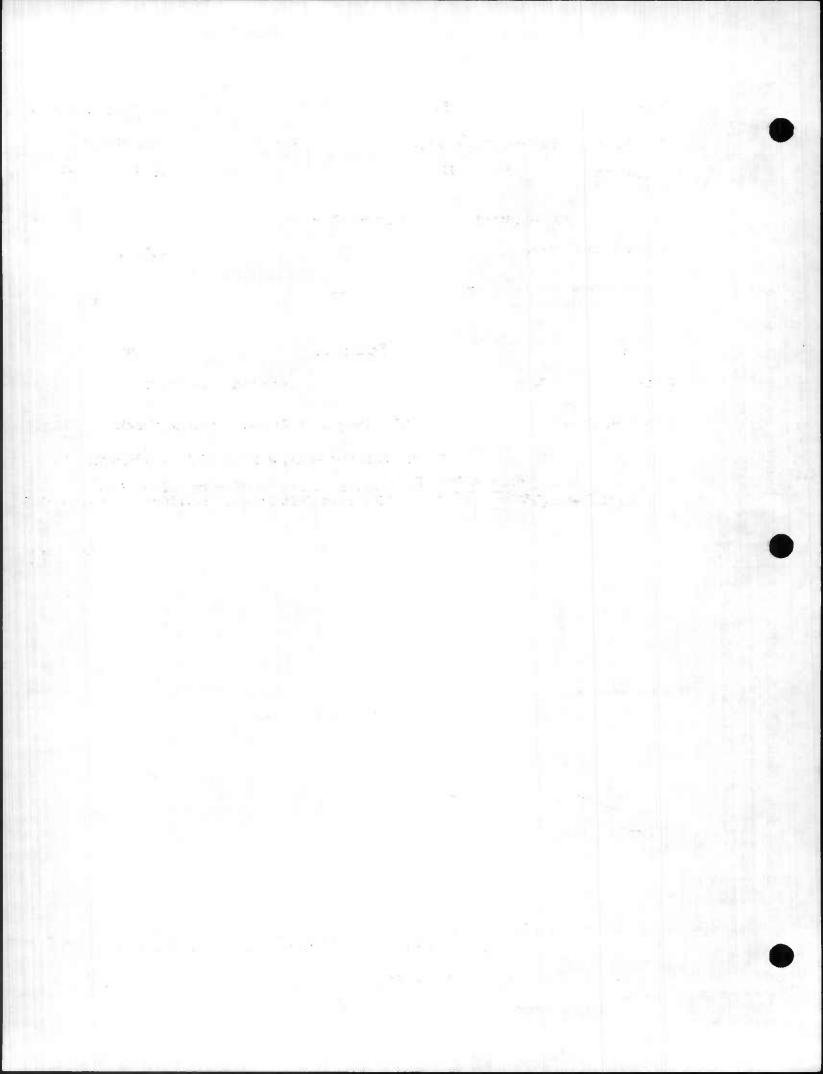
Boltimore Mayland 21217



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 6 6

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and a	4 □ Donalion 5 □ Other (Specify)  Delaware Valley Crematory, March 20,  21. Signature of Funeral Service Licenses Victor P. Doda, Jr.  Charles I., Stevens Fune													, o	
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ROSE, ANNA



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Doris Ellen Ravner MARCH 11:21 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BURNIE GIEN AA COUNT ARUNDEL 8. Date of Birth (Month, Day, Y Feb. 18, If Under 1 Year | If Under 24 Hrs. Year) 9. Birthplaca (State or Foreign Country) Mary Land 7. Age (In yrs. last b rthday) Days 215-24-2459 81 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1716 Tieman Drive 21061 United States Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1X Never Married 2 Married 1 Yes 2KHNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Joseph Rayner Annie Elizabeth Ludwig 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1716 Tieman Drive Glen Burnie, MD 21061 Donald Rayner/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State March 25, Burial 2 Cremation 3 Removal from State Baltimore, Maryland Western Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee Kirkley-Ruddick Funeral Home awak 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or cause on each line. Approximate Interval Between Onset and Death 20 Minules immediate Cause (Final disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Be Completed 24a. Was en autopsy completion of cause of death? 1 Yes 3€XNo 1 □ Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No edical Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be axecu Box 68760, P.O. I Division of Vitai Records.

the signed by 1 certificata this funeral After

**Funeral** 

Director

28a-f show

8

Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mentel Hygiene.

Department of

**Physician** 

/Medical

**Examiner** 

Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: A To the

State

29c. License number

Highway

1 ☐ Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHOPRA MI 75

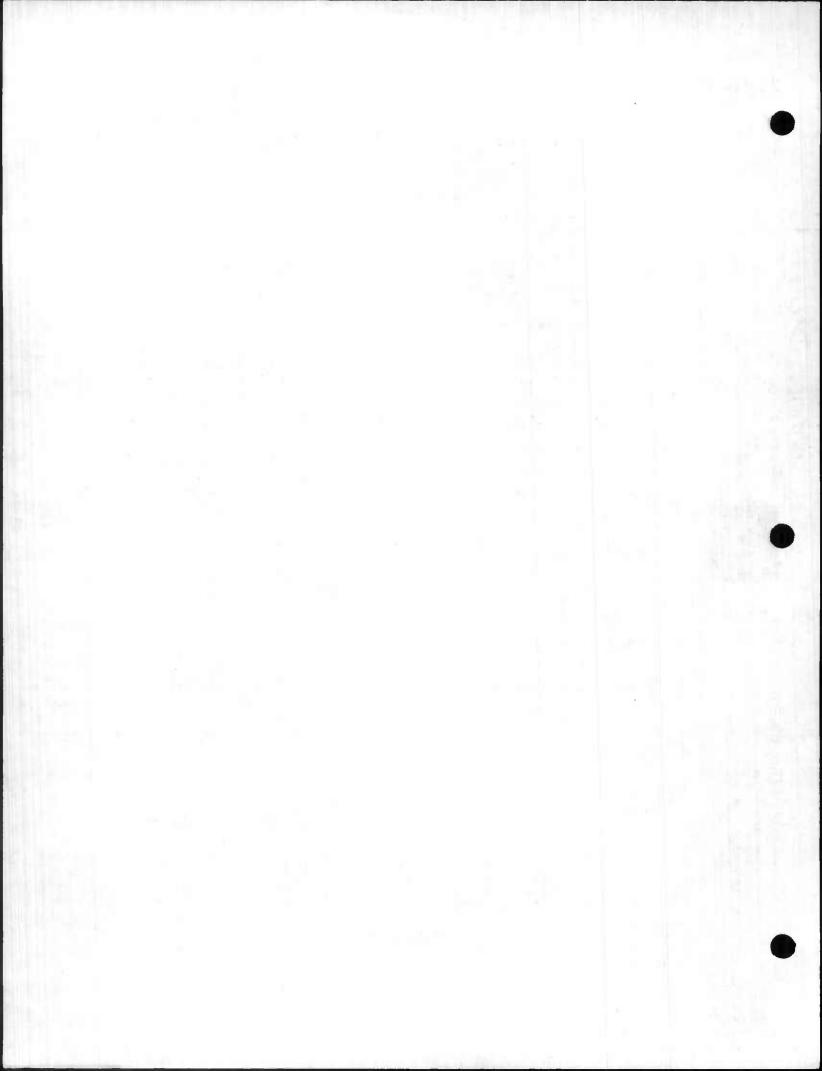
31. Date filed (Month, Day, Year)

29b. Signature end title of cartifier

29a, Certifier



Registrar



99-1492-510

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

DOROTHY
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State of Maryland / Department of Health and Mental Hygiene

DOROTHY	
RANDOLPH	

Certificate of Death 1. Decedent's Name (First, Middle, Last)

2. Date of Death Day 1999

Physician
' /Medical
Examiner

Director

Funeral

py

Completed

Be

10

0 4a Fecility Name (If not institution, give street and number)

Month MARCH

3. Time of Death 4:20P.M.

902 BUNCHE ROAD

4b. City, Town, or Location of Death BALTIMORE

4c. County of Death

10g, Citizen of What Country

**Funeral** Director 5. Sociai Security Number 218-12-6162 Usual Residence of Decedent

6. Sex 7. Age, (In yrs. last birthday) 1 M 2 K Yrs

If Under 1 Year

10f. Zip Coda

If Under 24 Hrs.

lace (State or Foreign

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural; or flerm 23a or 28a-f ahow any injury or other traumatic avent, the Health Evantine must be notified at

3altimore, Maryland 21215-0020

10a. State 10b. County Varyland

10c. City, Town or Location

10d. fnside City Limits 1 Yes 2 No

10e. Street and Number

11. Marital Status 2 Married

12. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:

14. Race American Indian Bieck, White, etc.

1 ☐ Never Merried

3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

(50n)

16a. Dacedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired)

unk.

16b. Kind of Business/Industry

Elamantasy/Secondary (0-12) d 17. Father's Name (First, Middle, Last)

18. Mothar's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify)

19a. Informant's Name/Reletionship (Type, Print),

20b. Place of Disposition (Name of cemetary, grematory or other place)

19608 ra. Reading Town, Stete 20c. Location - City of

e of Funeral Service Licens

22. Name end Address of Facility Sep. or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, List only one cause on each line.

ora 21216 Balto, Approximate Interval Between Onset and Death

**Physician** /Medical **Examiner** 

the attending physician and hed for use as the bunal-transit that the daath certificate be axecuted

signed by t

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funeral director,

this

To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After

Box 68760,

Division of Vital Records, P.O.

Examiner

Physician/Medicai

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Completed

Be

Certification: To

Medicai

Immediate Cause (Final disease or condition resulting in death)

APAONOSCONOTIC CARRIOVAGUES 018 Due to (or as a consequence of)

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events rasulting In death) Lest

Due to (or as a consequenca of):

Due to (or es a consequenca of):

Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Dfd tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No

3 Probably 4 Nunknown

24a. Was an autopsy DABOON

24b. Were eutopsy findings avaliable prior to completion of cause of daath?

1 Inpatiant 2 ER/Outpatient 3 DOA

28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 PResidence 6 Other (Specify)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1X Yes 2 No

27. Manner of Death

1 || Natural

2 ☐ Accident

3 ☐ Suicide

4 - Homicide

5 Pending

investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 Yes 2 🗆 No 28d. Dascriba how injury occurred

29a. Certifier (Check only one)

1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

MARCH 14, 1999

28f. Location (Street and Number or Rural Route Number, City or Town, State)

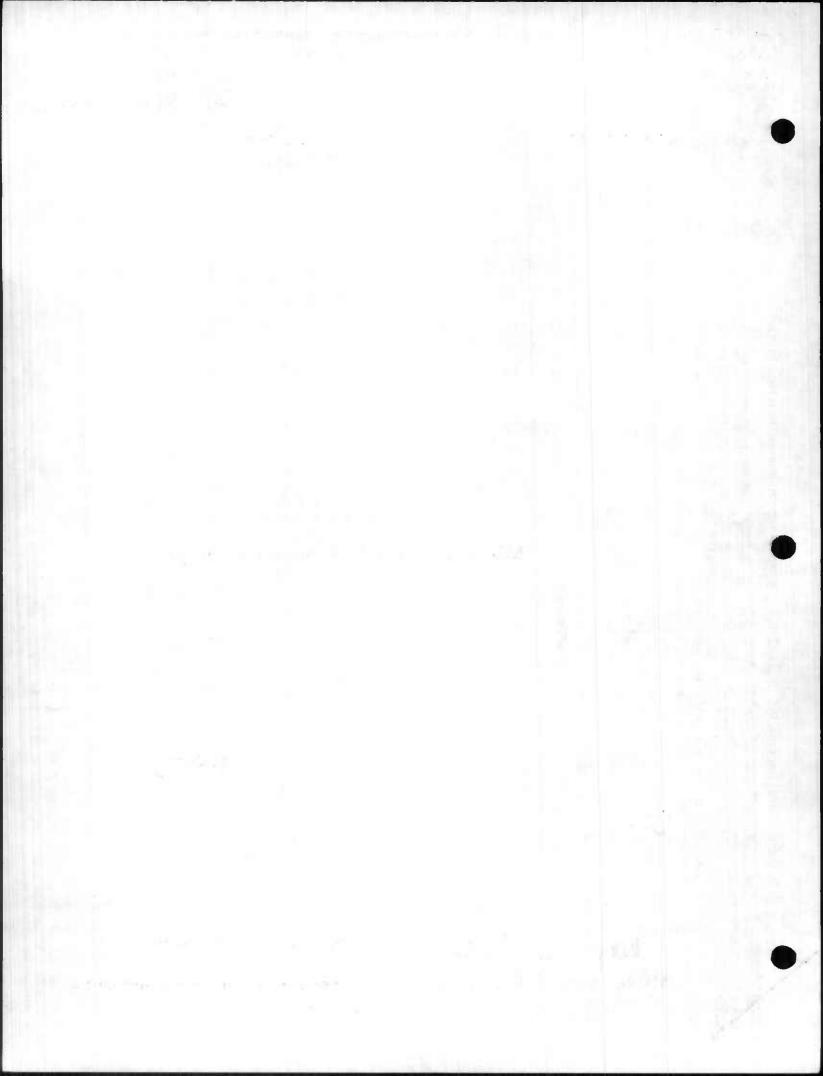
30. Name and address of person who complated causa of death (Itam 23a) (Type, Print)

31. Date filed (Month, Day, Year) MAR 2 2 1999

32. Registrar's Signature S-CANDO

111 Penn Street, Baltimore, Maryland 21201

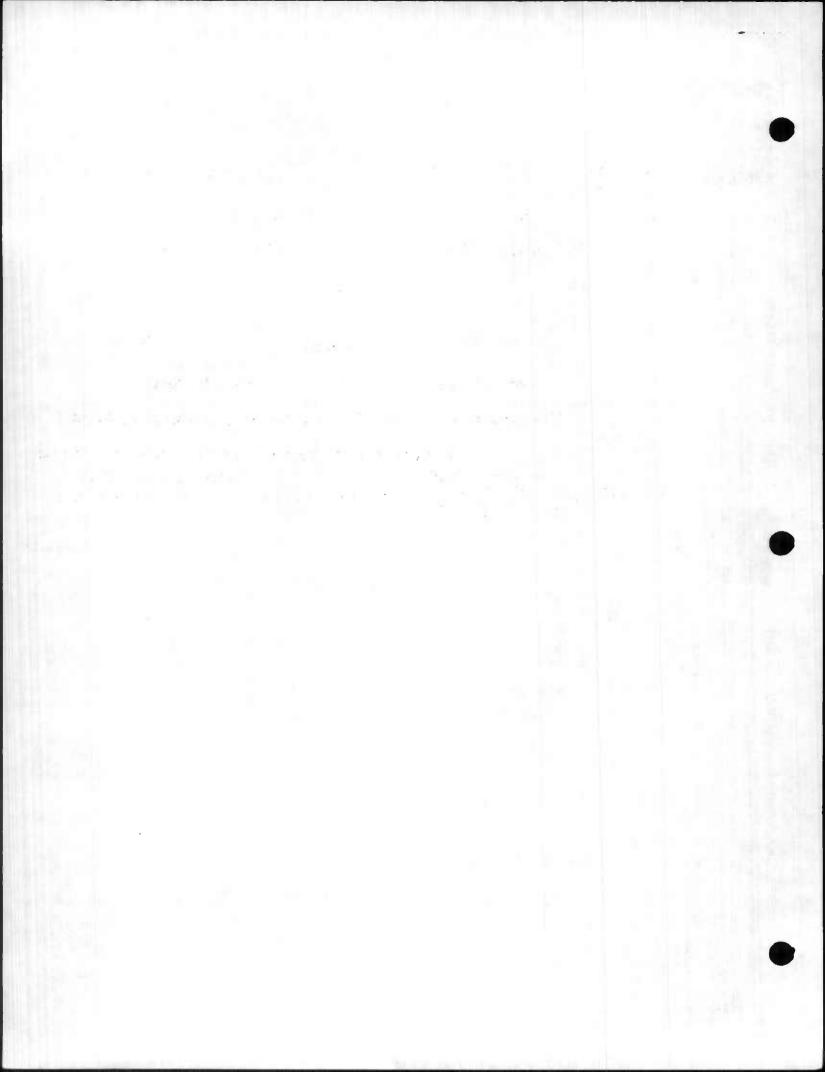
State Registrar



## Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					Cer	tificate	of Death		Reg. No.	090	) () ()			
	1. Deced	ent's Neme (First, Middle	e, Last)	0	1			2. Defe of De Month	onth Dev Year					
hysician /Medical		RUTH		RIL	2			MARCH		199 1	17:17 PM			
Examiner	A 71 Pro-	y Name (If not institution					4b. City, Town, or		th 4c. County		N. / A			
			NARITA.		PINAZ			more			N/A			
uneral rector	092-	Security Number -16-8711	6. Sex 1 □ M 2 🖄 F	7. Age (In yrs.	(last birthdey) () Yrs.	If Under 1 \ Months D	Yeer If Under 24 Hrs Deys Hours Min	(Month D	8, 1918	Country	ce (State or Foreign			
be notified at Director	Usuel Re	sidence of Decedent a 10b. County		10c. C	ity, Town or Lo	cation				100	d. Inside City Limits			
	Mo	1.	N/A				Baltimore	e City			1⊠Yes 2□No			
A 0	10e. Stre	et end Number 302	21 Overla	and Aven	ue	10f. Zip Co	2121 <sup>4</sup>	1	10g. Citizen of V					
is marked other than "natural", or items 23s raumetic event, tra Medical Examination and To Be Completed by Funeral		al Status lever Merried 2 Marri Vidowed 4 □ Divorced	Armed	ecedenf Ever in U Forces? s 2 🔯 No Give Dates:			t of Hispenic Origin? ( Cuben, Mexican, Puer No Specify:	Specify Yes or N rto Ricen, etc.)	o- 14. Rec Blac Specify	ce - American ck, White, etc	White			
		15. Decedent (Specify only highes	t's Education	4)	16e. Deced	dent's Usuel C	Occupation	orkina	16b. Kind of B	usiness/Indu	stry			
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marked o	19e. Info	rment's Neme/Reletions	hip (Type, Pnint)		19b. Meilin	ng Address (S	Street and Number or F	Rurel Route Numi	ber, City or Town,	Stete, Zip C	Code)			
trait	Ber	rtram V. Ril	ll (Hus	sband)	302	21 Over	rland Avenu	ue Balti	imore. Me	d. 212	14			
nrt: if Nem 27 is marked other ury or other traumatic event, To Be C	121	nod of Disposition Buriel 2 Cremetion		- Cana	Plece of Dispo cemetery, cren	sition (Name natory or othe	of	Dete	20c. Location	City or Town				
rinic		Donetion 5 Other (S)						1						
Important: If any injury or once.	21. Signe	ofure of Funeral Service I	Historia Milto	on J Knigh			Address of Fecility  rford Road		J. Ruck					
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iner	resulting	In deeth)	a	Due to (	or es a conseq	uence of):								
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EX EX	if eny, lea	ally list conditions, ading to immediate inter Underlying bisease or Injury ted events												
edicai	that Initie	ded events	C	cDue fo (or es e consequence of):										
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for use														
ysi y	Pert II. Ot	her significant conditio	ns contributing to	death but not res	sulting In the ur	nderlying ceus	se given in Pert I.		23b. Did tobacco use contribute to the cause of					
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page 2 should be d								24e. We	s en eutopsy formed?	eveil	e eutopsy findings leble prior to pletion of cause			
19 E										of de	eeth?			
rector, page								1 🗆	Yes 2 No	10	Yes 20 No			
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ion	LEN	eturel 5 Pendin		e of Injury onth, Day Year)	Injury	M 260.	Injury at Work? 1 ☐ Yes 2 ☐ No	200. Describe	riow injury occur	occurred				
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= C	4 ☐ Homicide  5 ☐ Could flot be determined building, etc. (Specify)  28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)													
Med in				no hoot of my kny	owledge, deeth	occurred et f	the time, dete end plea	e, end due to the	e ceuse(s) end m	enner as stat	ted.			
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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Smits Month LUCILLE Is ro Have 5: 15 AM Mar 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Hospital 10 wson JOSEPH BALTIMORE If Under 24 Hrs. Hours Min. If Under 1 Yeer Birthplace (Stata or Foraign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10 M 20F Days 215-34-7557 Yrs. Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMOR Touson TUYas 2□ No Marylows 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U52 AUG LENnox 21286 305 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedant Evar in U,S. Armed Forcas? 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus 1 Nevar Married 2 Married 1 Yes 2 No If Yes, Give Year or Detes: 1 Yes 200No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) SEY-EmplyED College (1-4or 5+) Private Duty 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sugname) EMMA JAME GATONER THOMAS W. GARDNER, 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Towson, Med 21286 305 LENNOX AUG HUSBAN Walter smith 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetary, cremetory or other place) 20c. Location - City or Town, Stete Degurial 2 Cramation 3 Removal from State Monerial Omes 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility CAATMEN / Imm's 21. Signeture of Funerel Sarvice Licensee Baltonery ord 212 in Roiso Harra 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or near feiture. List only one cause on each line. Approximate Intervel Between Onset end Deeth Immedieta Causa (Final disaase or condition resulting in deeth) Due to (or as a consequenca of): Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initialed evants rasulting in death) Lest Due to (or es e consequence of): D (Chronic Obstructive Pulmonary Discase) Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Examiner attending physician and for use as the bunal-transit Physician/Medical by Completed Be P Certification:

**Physician** 

/Medical

Examiner

Director

Funeral

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Funeral

Director

ir than "natural", or itema 23a or 28a-f ahow The Medical Examiner must be notified at

pernit. Pages 1 and 2 should be filed within 72 hours after death to Department of Haelth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumetic event, the Hedical Example mass.

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

the Maryland

Box 68760. Division of Vital Records, To the Hospital or Attending P within 24 hours aftar daath. To the Funeral Director: After filled in by

DHMH 16 Rev 6/95

Registrar

edical

(Check only one)

3rd Floor Morgan

MAR 2 2 1999

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Builling

32. Hegistrer's Signeture

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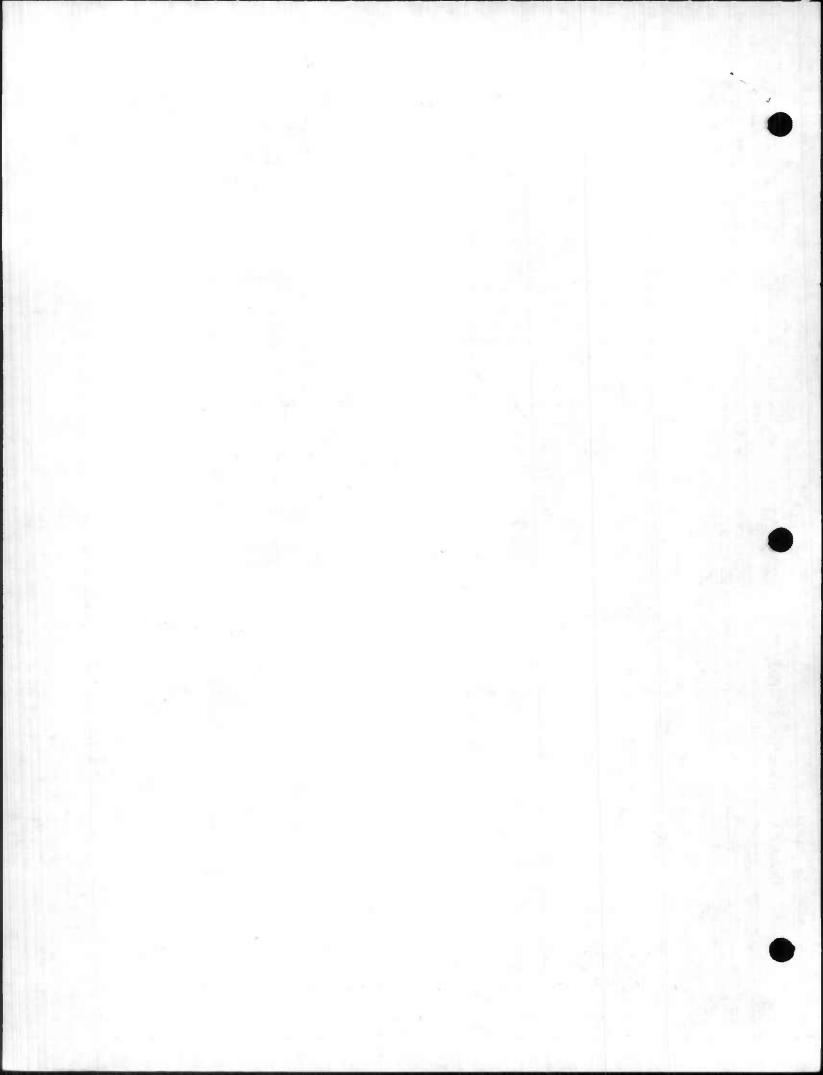
3601 Loch Koven

29c. License number

**ORIGINAL** 

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steled. 29d. Dete signed (Month, Day, Year)

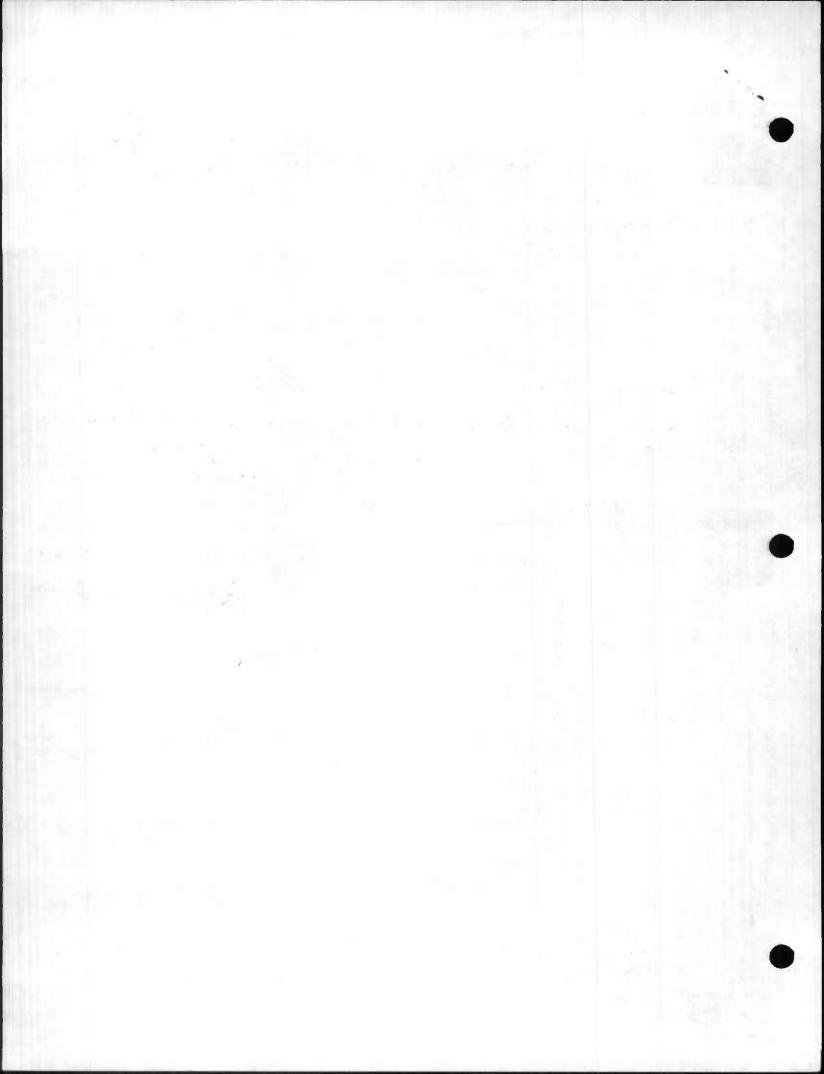
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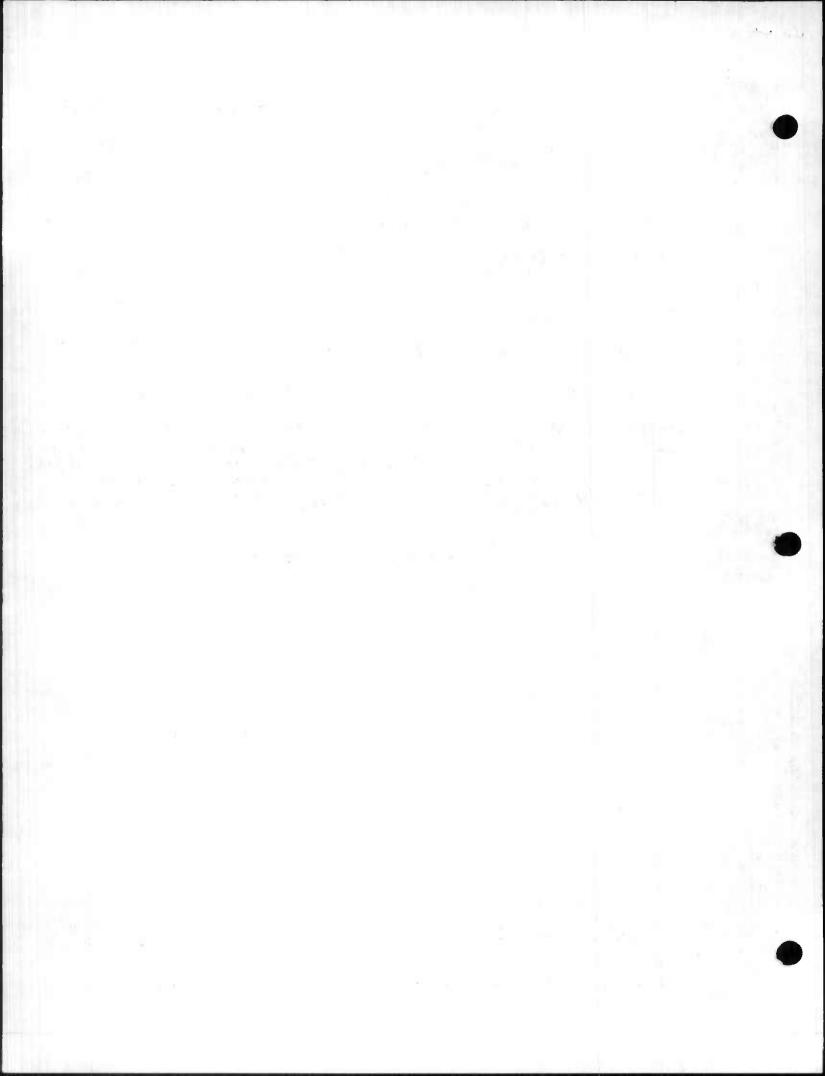
Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** SERAE. STOKES 3:43 A.M 1999 MARCH /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE NIA SAMARITAN HOSPITAL (200D) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplece (State or Foreign Country)

Carylass **Funeral** 10M 20F Days 218-86-3067 Usual Residence of Decedent 37 Yrs. Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygians. Important: If Item 27 is marked other than "natural", or items 23s or 28s-4 show should you've or high or but all the field of the taumatic event, the Medical Exercities man be notified as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BAITIMURE LATES 2 No Directo Karylows 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2125 PEUTLAND USA 21234 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Reca - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Never Married 2 Married 1□Yes 2 No Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home HOME MAKEY 4EARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Madeline E. Lowis DAVID 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Fairmount Ave BA/440E, Led 21286 Kadeline 20b. Place of Disposition (Name of cemetery, crematory, or other place, 20a. Method of Disposition TOKES Burial 2 Cremetion 3 Removal from State 4 □ Donation 5 □ Other (Specify) CHEROLD 22. Name and Address of Facility CHA TAYAN - HARNI'S 21. Signature of Funeral Service License 23a. Part1. Effect the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical OBSTRUCTION - HEMOPTYSIS AIRWAY O MIN **Examiner** Due to (or as a consequence of) Be Completed by Physician/Medical Examiner DAYS NEUMONIA attanding physician and for usa as the bunal-transit or Attending Physicism: The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequenca of): ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown PNEUNONIA, 24b. Were autopsy findings available prior to completion of cause of death? Aftar this certificata has been si funaral director, paga 2 should 24a. Was an autopsy performed? RETINITIS 2000 25. Was cese referred to medicel 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending n 24 hours after death.

Ne Funeral Director: After plately filled in by the fur 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 3 Suicide 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edicai compiately 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the F within 2 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier MARCH, 15, 1999 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) SAMARITAN BALTIMORE HOSPITAL, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State General Registrar MAR 221999



Item#2	Da perFHG769 3/22/99FW	•		ent of Health and ate of Death		Reg. No. 9	090	72			
Physician /Medical	1. Decedent's Name (First, Middle, La Magdall N	Scholl			2. Date of De Month March	Day	Year	ime of Death			
Examiner Funeral Director	4a. Facility Name (If not institution, gives Shell and Fig. 5. Social Security Number 6. Shell and Shell a	3	last birthday) If Und Month	der 1 Year   If Under 24 Hrs s Days Hours Min.	ım	Ball th ty, Year)					
or 28=4 show	10a. State 10b. County	MAO 0	ty, Town or Location					ide City Limits Yes 2 No			
should be filled within 72 hours after death with the Maryland and Mental Hygiena.  marked other than "natural", or items 23e or 28e-1 show unatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	10e. Street and Number  2447 (L) OOM (P)	At ld	10f. :	Zip Code 21234		10g. Citizen of	What Country?				
burs after death with the Maryla lat', or items 23e or 28e-f sho Everine man be notified at by Funeral Director	11. Marital Status  1 ☐ Never Marrled 2 ☐ Merrled  3 ☑ Widowed 4 ☐ Divorcad	2. Was Decedent Ever in U Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates:	If Yes, s	pedent of Hispanic Origin? (Specify Cuban, Mexican, Puer 250 No Specify:	Specify Yes or No to Rican, etc.)	- 14. Rac Bla Specifi	ce - American Ind ck, White, etc. y: While	an,			
be filed within 72 ho tal Hygiena. d other than "natura event, the Medical Be Completed	15. Decedent's E. (Specify only highest gra		16a. Decedent's U: (Give kind of life, DO NOT	vork done during most of wo	rking		usiness/industry	om.			
merked othe imatic event,	17. Fether's Name (First, Middle, Last, URIG) 19a. Informativs Name/Relationship	ht	19h Mailing Addre	18. Mother's Nai	me (First, Middle,	Chonn	ell				
and 2 ealth a n 27 is	20e. Method of Disposition  1 Sourial 2 Cremation 3  4 Donation 5 Other (Specif	Removal from State	2447 U	Joodcroft Rd	Balty March 21	more, 1	1d 2/2: - City or Town, St	34			
Departme Importan eny injur once.	21. Signature of Funeral Service Licer	I Wells	2 8800	and Address of Facility Ex	e Balti	rorest ineral	Chapel Md 213	ikyluna 134			
Physician /Medical Examiner	23a. Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. CHRONIC O.		PULMONARY DI		rrest,	Interv	eximate al Between t and Death			
phys s the	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	b. GENERAL A.  Due to (c	RTERIOSCLE, or as a consequenca o	ROSIS							
d by the etach	Part II. Other algnificant conditions o	ontributing to death but not res	ulting in the underlying	g cause given in Part I.			contribute to the cause of death				
been s should					24a. Was	en autopsy rmed?	24b. Were eut avalleble completic of death?	opsy findings prior to on of cause			
certificate hirector, page	25. Was case referred to medical			29. Place of De	ath (Check only o	Yes 2⊠No	1 ☐ Yes	2□ No			
this certific ral director.	examiner? 1 ☐ Yes <b>Ž(X</b> No	Hospital: 1 inpatient 2 28e. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of	044	lome 5 ☐ Resi	dence 8 Oth					
within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	27. Manner of Deeth  ***Natural 5 Pending investigation 3 Sulcide 6 Could not be determined	28f. Location (	28d. Describe how Injury occurred								
within 24 hours after the Funeral Direct to the Funeral Direct completely filled in Medical Cert											
ithin 24 omplets	one)  29b. Signeture and Mor certifier	and menner stated.		9c. License number	irred at the time,		end due to the ca				
	10 de	soft r	2	D 15504		3	18. F8	?			
13	30. Neme end address of person who Eddie Nakhuda, N		n 23a) (Type, Print) laney Vall	ey Rd Timo	nium, Mo	21093					
State Registrar	31. Date filed (Month, Day, Year)  MAR 9	32. Registrar's Signation		Sports!							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** SHECTER CHARLES MARCH /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deett Examiner NONTHWEST HOSGITAL RANDAILE TOWN BALTI MORE If Under 1 Yaar | If Under 24 Hrs. 5. Sociel Security Number 8. Dete of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) 7. Age (In vrs. last birthdev) **Funeral** Deys 1X M 2□ F Months Hours Min 085-42-7435 July 24, 1951 New York Director Usual Residence of Decedant the Maryland 10e Stete 10h County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f shov soics! Examiner must be notified at 1 Yes 2 No Maryland Baltimore County Windsor Mills Director 10e. Street end Number 10f, Zip Code 10g. Citizan of Whet Country? 7418 Hindon Circle, unit 102 21244 U.S.A. Funeral 72 hours after death 12. Wes Decedent Ever In U,S. Armad Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 14. Rece - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Merried Specify: White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry ent, the Medical 15. Decedent's Education (Specify only highast greda completed) se filed within 7. sal Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Technical Consulting Computer Programmer 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be and Mental H Pages 1 and 2 should be 1 nent of Haalth and Mental Finkelstein Shecter Freda Sidney 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21244 19e. Informent's Name/Reletionship (Type, Print) or other tra 7418 Hindon Circle, unit 102, Baltimore, Maryland Meryl A. Shecter (wife) Baltimore, 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State MAR.21 1 ☐ Burial 2 X Cremation 3 ☐ Ramovel from Stata permit. Page Department of Important: If any injury or Laurel, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore/Washington Crematory 21. Signatura of Funeral Sarvica Licensea 22. Name end Address of Facility Loring Byers Funeral Directors, Inc. Party Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac above, or heart feiture. List only one cause on each line. 8728 Liberty Rd. Randallstown, Maryland 21133 Approximate Intervel Between Onset end Deeti Physician 4 Days MUJORANDIAL INFARATION /Medical Immediate Ceuse (Finel disaese or condition resulting in death) Examiner Examine Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events rasulting in death) Last Due to (or es e consequence of): physician a s the burial-Box 68760 8 Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. ENCEPHALOPATHY! Hypertonsion; 1 Yes 2 No 3 Probably 4 Unknown ř signed t à 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy Completed RETINOPATH 1 Yes 2 THE 1 Yes 2 No 25. Wes case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospitel: 1 Departiant 2 ER/Outpatlent 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yas 2 No the party 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Neturel 5 Pending 1 Yas 2 No Investigation 2 Accident

Division of Vital Attending Director alle. b Funeral D taly filled hours 28

Medical To the 2 Registrar

29c. Licanse number

32. Registrar's Signeture

28a. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Decrifying Physician: To tha best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end manner es steted.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29d. Date signed (Month, Day, Year) 119502

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) B. CONTANAN RED

MAR 2 2 1999

6 Could not be determined

3 ☐ Suicida

29e. Certifier

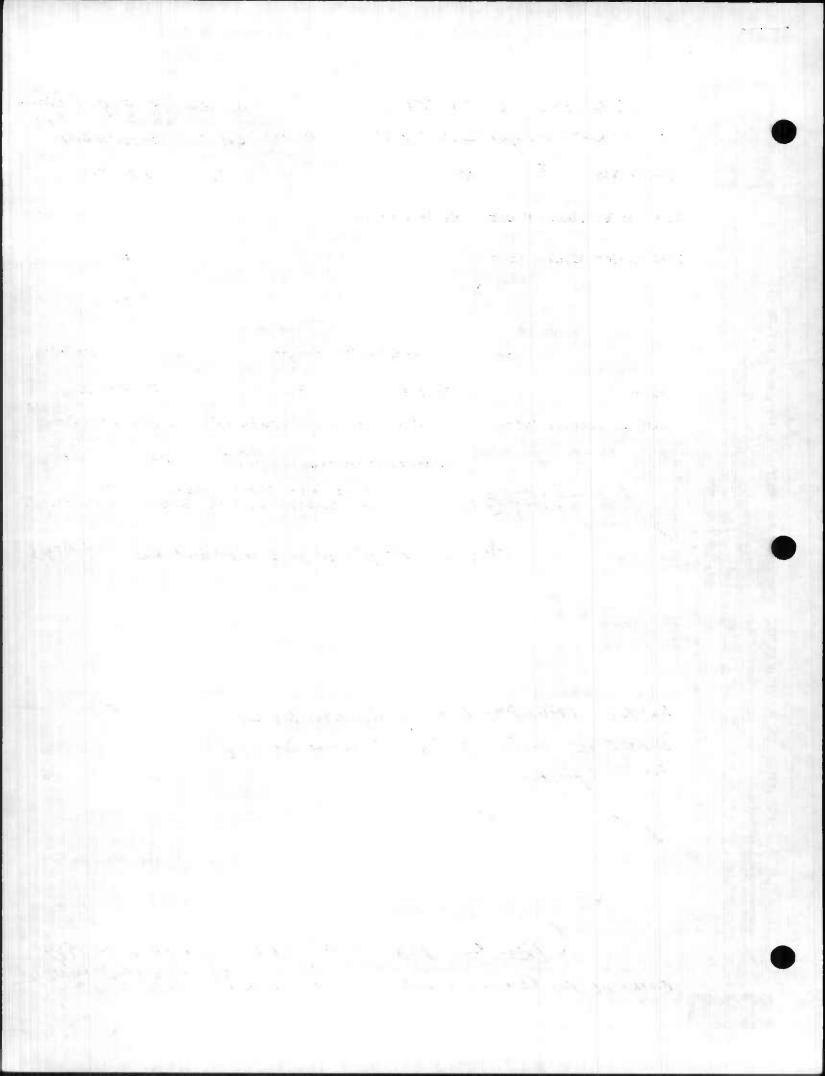
4 Homicide

(Check only one)

29b. Signeture end title of certifier

19214NO0 31. Dete filed (Month, Dey, Year) RAND +160 TOWN

28f. Location (Street and Number or Rural Route Number, City or Town, State)



### Piease Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 10:00 AM 15, 1999 March Κ. Stinehart 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Brooklandville Brightwood Center If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months Deys Hours 1 M 2 F Yrs. 82 Nov. 6, 1916 Maryland 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No **Brooklandville** Baltimore 10f. Zip Code 10g. Citizen of What Country? 21022 U.S.A. 515 Brightfield Road 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 22 No If Yes, Give Year or Dates: 14. Raca - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced White 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry Coilaga (1-4or 5+) -0-Administrative Assistant Johns Hopkins University 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last)

Mabel M. Schriver

200 Logation - City of Town State

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

Data

59 S Benton Woods Circle The Woodland, TX

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumstic event Director Funeral by Completed Be 2

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

Ruth

5. Social Security Number

Usual Residence of Decedent

Eiamantary/Secondary (0-12)

Mrs. Lynn Berry

12

On Mathed of Disposition

10b. County

William F. Kershner

19a. Informent's Name/Relationship (Type, Print)

215-03-7201

Maryland

11. Maritei Status

10e. Street and Number

10a, Stete

Physician /Medical Examiner

29b. Signatul

31. Data filed (Month, Day, Year)

MAR 2 2 1999

end eddress of person who completed causa of death (Item 23e) (Type, Print)

515

32. Registrar's Signeture

Division of Vital Records, P.O. Box 68760, USe Hospital or Attending Physicien: death. To the Hospital within 24 hours e To the Funerel C completely

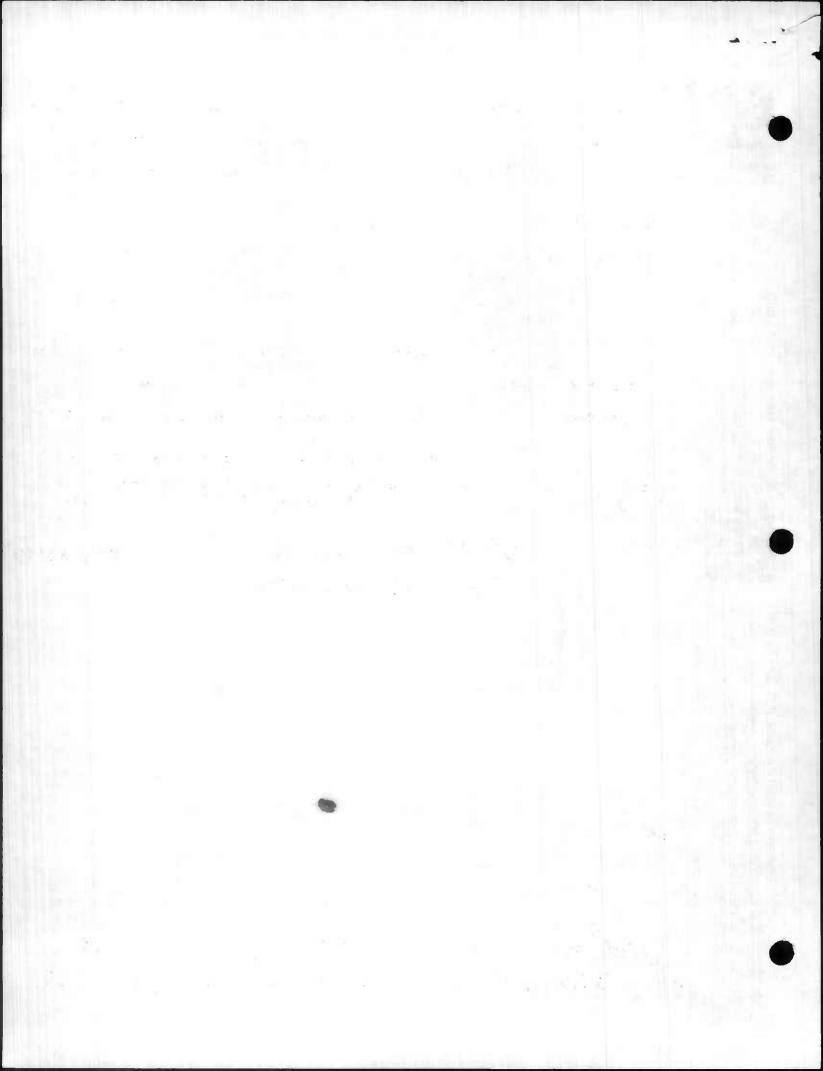
1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel	from State cemeter	y, cremetory or other	her place)			Only or voting one			
4 ☐ Donetion 5 ☐ Other (Specify)	Lake '	View Mem	. Park	3/18/99	Sykesvi	ille, MD			
21. Signature of Funeral Service Licensee	Lenkins	Loring :	Address of Fedility Byers Fune: berty Road				2		
23a. Pert1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do no each line.					Approx			
Immediate Ceuse (Final disease or condition resulting In daath)	Dua to (or al a c	Med N consaquance of):	16117			Few	wed		
Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or es e o		ruen to			1			
cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest	Due to (or es e c	onsequence of):							
d	to death but not resulting in	the underlying ca	use given in Part I.	23b. Dld	lobacco use col	ntributs to the ca	use of deati		
				10	Yss 2 No	3 Probabty	4 Unknow		
				24a. Was perfo	en autopsy rmed?	24b. Were euto evellabla p completion of deeth?	orior to		
				10	res 20 No	1 ☐ Yes	2□ No		
25. Was case refarred to medical			26. Pleca of I	Deeth (Check only o	ne)				
examiner? 1 Yes No Hospitel:	1 Inpatient 2 ER/Ou	tpetient 3 DO.	A Other: 4 Nursin	g Home 5 ☐ Resid	dence 6 Oth	er (Specify)			
27. Manner of Death  11 Anatural 5 Pending 2 Accident investigation		ry Year) 28b. Time of			28d. Describe how injury occurred				
3 Suicide 6 Could not be determined 28a.	Plece of Injury - At home, febuilding, etc. (Specify)	rm, street, fectory,	office	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)					
29a. Certifier Check only 2 Madical Examiner: On	o tha bast of my knowledge, the basis of examination end	, death occurred a Vor investigation,	t tha tima, data and plain my opinion, daeth o	aca, and dua to tha ccurred et the time,	causa(s) end ma date end place,	annar as steted. and due to the ce	use(s)		

29c. License number

Fair may

20h Piece of Disposition (Name of

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 15, 1999 1:37AM MARY JANE SCHARF MARCH 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE N/A 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthpiace (State or Foreign Country) Days Months Hours 1 ☐ M 2 🖫 F 72 214-24-3216 MAR. 15, 1927 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ty Yes 2 No MD. N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5006 CROSSWOOD AVE. 21214 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 ☐ Merried 1 ☐ Yes 2√ No If Yes, Give XX Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) NEVER EMPLOYED N/A N/A 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) **JAMES** W. SCHARF, SR. LILLIAN SPEAR 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES W. SCHARF, JR./BROTHER 3145 WHEATFIELD RD. FINKSBURG, MD 21048 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/18/99 LAUREL, MARYLAND BALTIMORE WASHINGTON CREMATORY 22. Name and Address of Fecility 21. Signature of Funeral Service Licenses LORING BYERS FUNERAL DIRECTORS, 8728 LIBERTY RD., RANDALLSTOWN, INC. MD 21133 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart tailure. List only one ceuse on each line. Approximete Intervel Between Onset end Death 3 weeks Immediate Cause (Final disease or condition resulting in death) Schizabhreni Due to (or as a consequence of) Due to (or as a consequence of)

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

mast be notified at

Herna 23a

permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mentel Hygiene. Important: If Nam 27 is marked other than "natural", or then any Injury or other traumatic event, the page.

Director

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Completed

Be

physician and the bunal-transit The law requires that the deeth certificate USB

Box 68760.

this

Division of Vital Records, P.O. or Attending Physician: hours after death. To the Hospital o within 24 hours af To the Funeral Di completely filled is State

Examine Physician/Medical þ Completed Be edical Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy tindings evailable prior to completion of cause of death? 24e. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical examiner?
1 1 Yes 2 □ No 26. Place of Deeth (Check only one) 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only 29b. Signeture and title of certitier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar **DHMH 16 Rev 6/95** 

Blakely

32. Registrar's Signeture

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print)

MAR 2 2 1999

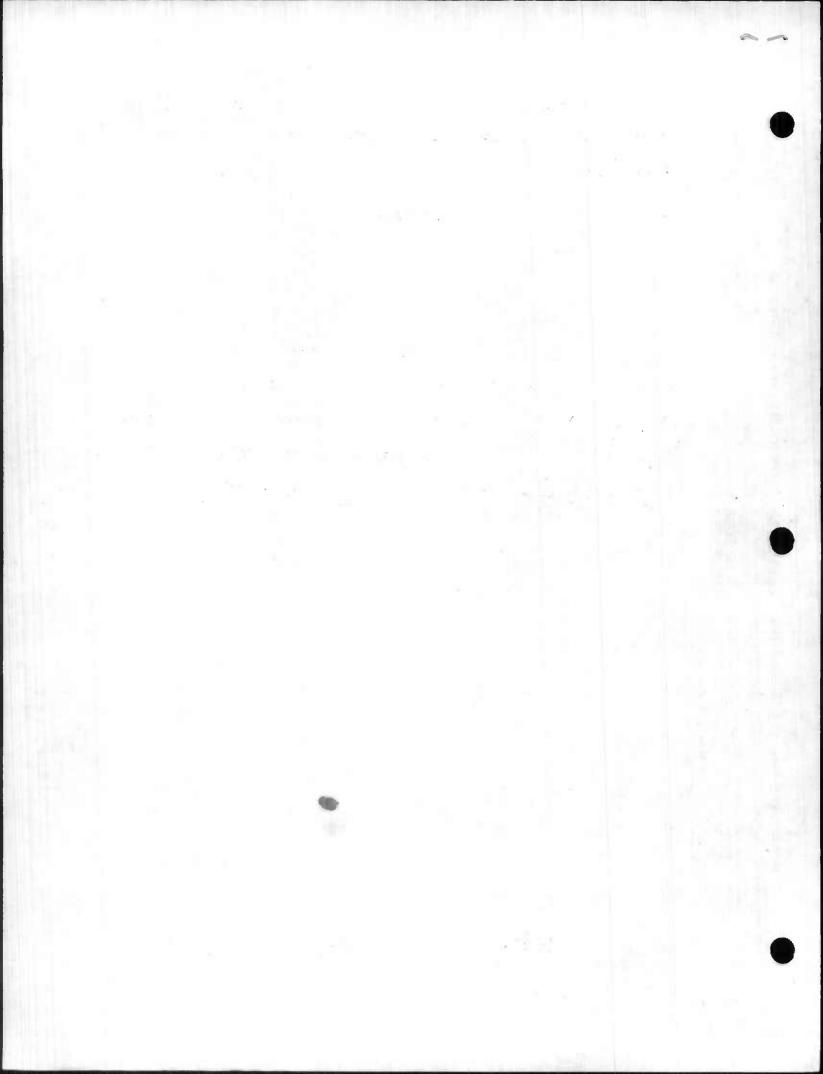
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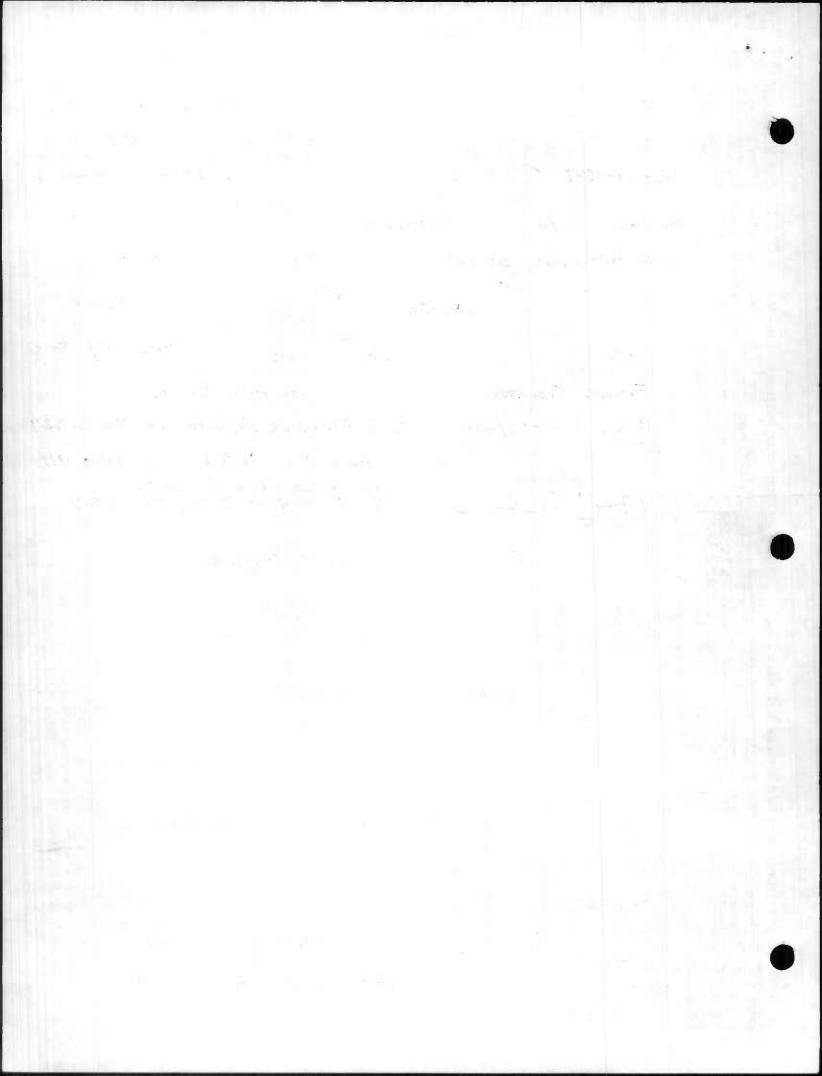


## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

JAMES THORNTON

State of Maryland / Department of Health and Mental Hygiene \( \cap \cap \cap \)

Decomption Name of the contribution gray solution of the contribution of the contribut					Certifica	ate of	Death		Reg. No.				
Formation in Serial Name of the other parts and entire registered in an internal control of the serial name			1. Decedant's Nama (First, Middla, La	ist)					of Daath		3. Tima of Desth		
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Directors    Control   Con			4a Facility Nama (If not institution, given	4a Facility Nama (If not institution, giva street and number)									
Director    Director	L		5 Social Security Number 6 5	Sex 7 Age /In vrs	last hirthday) If Und	dar 1 Yaar	If Undar 24	Hrs. 8 Data	of Birth	9 Birtho	iace (State or Foreign		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Fthe March 2050 Thurnton 15 /Medical 4b. City, Town, or Location of Deeth 4c. County a 4a Fecility Name (If not institution, give street and number) Examiner Baltimore Medical System University Manyland If Under 1 Year | If Under 24 Hrs. (State or Fpreign **Funeral** 1□M 2♥F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f ahow Stet 10b. County 10d. Inside Oity Limits City, Town, or Location item 27 is marked other than "natural", or items 23s or 25s-f show other traumetic avent, the Medical Example must be notified at 1 Yes 2 □ No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number d Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cubah, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 □ Divorced To Be Completed 16a. Decedent's Usual Occupation
Give kind of work done during most of working
life. DO NOT use retired)
HOUSCW/F 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Malden Surname) Sori 20a. Method of Disposition Important: If It any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 Donation Dother (Specify) the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. the mode of dving, such as cerdiac or respiretory arrest. Physician /Medical Immediate Cause (Finel 4 months csophagea Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and for usa as the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): signed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23h. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were eutopsy findings avelleble prior to completion of ceuse of deeth? pluods Completed 24a. Was an eutopsy performed? page 2 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Atlanding Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No To 1 inpatient 2 □ ER/Outpatient 3 □ DOA After this 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 ☐ Accident 3 ☐ Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🔣 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end manner as stated. Medicai (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and plece, and due to the cause(s) and menner stated. To the F 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier March 15,1999 10050589 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) Greene St Baltmore, mp South Cunthia 0 MU

DHMH 16 Rev 6/95

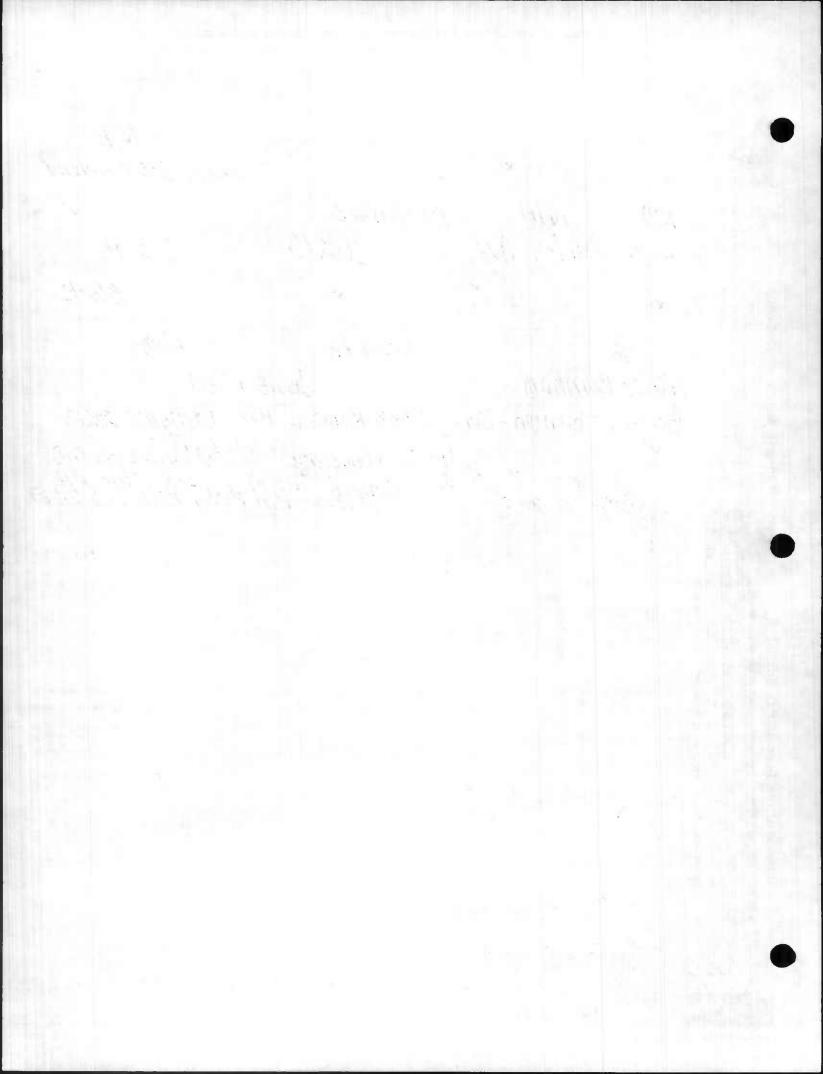
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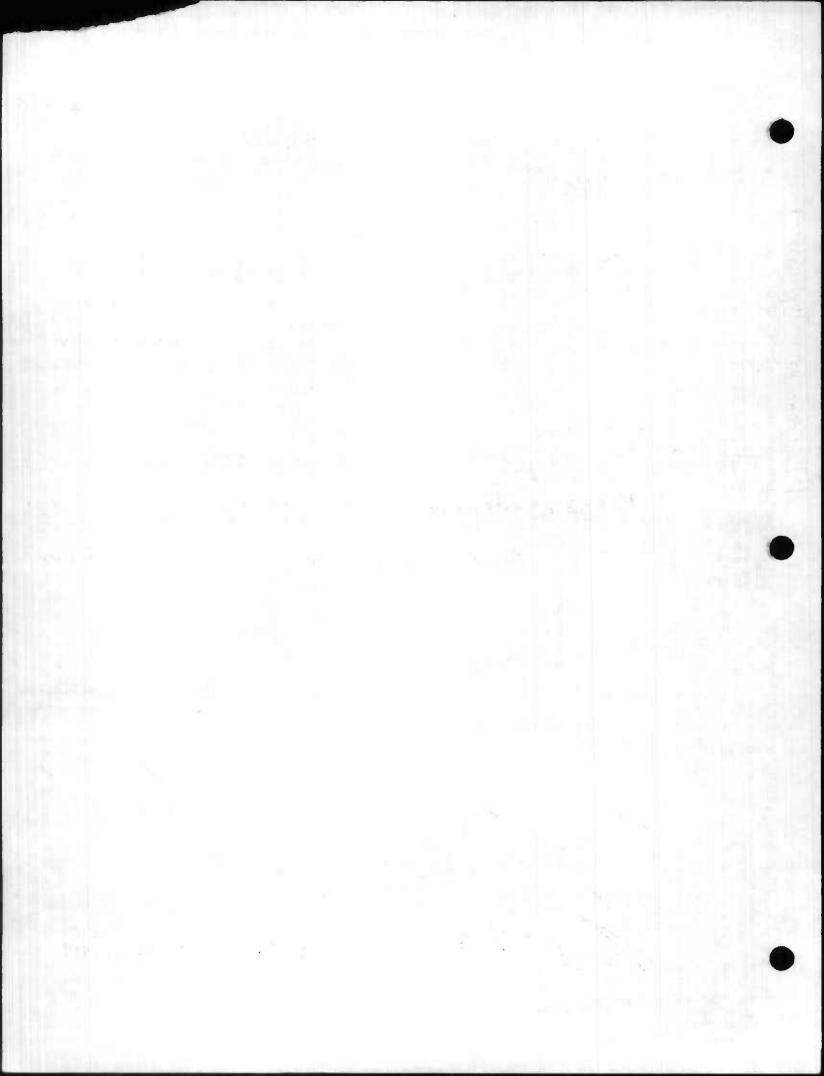
31. Date filed (Month, Day, Year)

MAR 2 2 1999

32. Registrar's 6ignature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 12:54 PM Carmon Taylor March 1999 16 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva streat and number) 4c. County of Death Examiner Sinar of Bultimore Baltimore Hospital If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** 1) M 2 F 244-48-6565 Yrs. Director 10-11-193 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: if item 27 is merked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinal must be notified at ence. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No Baltimore Director NA Ma 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Beau fort 4715 Avenue S. A U. 21215 Funeral 14. Raca - Amarican Indian, Black, Whita, afc. 12. Was Decedenf Ever In U,S. Armed Forces? Was Dacedanf of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 1 Nevar Married 2 Married 1 ☐ Yes 2 No 1□ Yes 2 No by Specify: Black 3 Widowed 4 Divorced Yaar or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) University Hospital Elementery/Secondary (0-12) College (1-4or 5+) 5-th NA Krown as 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert hottie 2 laylor 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4715 Beautort Balto Hd 21215 Avenue Willie Mae Taylor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Randallstown, nd 3-20-99 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 122. Name - F. M. Aurch F. M. 4300 21. Signature of Funaral Sarvica Licensea 22. Name and Addrass of Facility F.H. Wes! 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Avenue 21215 Approximate Interval Betwaen Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 2 years Metastatic ung Lancer Examiner Due to (or es e conseguence of): Physician/Medical Examiner physician and s the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): ettanding phi for use es t 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 1 Ves 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed s certificata has b director, page 2 s 2 1 No 2 3 No 25. Wes case referred to medical examiner?
1 ☐ Yes 2 No
27. Manner of Deeth Hospital or Attending Physician: Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) funerei 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 Neturel deeth. 1 ☐ Yes 2 ☐ No 2 Accident efter deeth Director: 6 Could not be determined n 24 hours efter dec ne Funeral Director pletely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated. Medical To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifian 29c. Licansa number -000 March 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SINAI Hospital ANDEZ, Mich 32. Registrar's Signeture 31. Date filed (Month, Day, Year) MAR 2 2 1999 Registrar



### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 0907

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):	Exami		4a. Fecility Neme (If not institution, give street and number)		4b. City, Town, o	r Location of Deeth	4c. County of Death	
				dical Syst		Limore	MA	
L	<sub>e</sub> Funeral Director		5. Social Security Number of Sex 12M 2 F 7. Age (In Usual Residence of Decedant	Yrs. last birthday) If Uni Month	der 1 Year If Under 24 Hi ns Deys Hours Mi		9. Birthp	olece (State or Foreign otry) 911112
	yland			c. City, Town or Location			1	0d. Insida City Limits
	the Men 28a-f sh	Director	Maryland N/A		O C Zip Code	100	China of Mina Carr	1 XYes 2□No
	ath with	eral Dir	1402 Madison Au	Je.	21217		Citizen of Whet Coun	A
020	within 72 hours after death with the Meryland ene. than "nature!", or items 23s or 28s-f show the Medical Exercites must be notified at	by Funeral	11. Meritel Stetus  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Wes Decedent Ever Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Yeer or Detes:	If Yes, s	cadent of HispenIc Origin? (pecify Cuben, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Reca - Americ Bleck, White, Specify:	
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pue	ould be filed with Mental Hygiene. arked other thar atic event, the	Be	17. Fether's Neme (First, Middle, Last)	C -	18. Mother's N	ame (First, Middle, Mai	dan Sumama)	
Maryland	should ind Men	5	199, Informent's Name/Reletionship (Type, Print) (Fre	ST.	Su	SIETTA	Churc	n
	1 and 2 sho Health and Am 27 is me		199 Informent's Name/Reletionship (Type, Print) (FIRE	437	Street and Number or F	Ba 1+	- MA I	21201
altimore,	permit. Pagas 1 and Department of Health Important: if Itam 27 any Injury or other tr once.		1 Buriel 2 □ Cremetion 3 □ Removel from State	Ob. Plece of Disposition (A cametery, crematory of	Nama of prother place)	3 5 3 0 1	Location - City or To	
<b>Baltin</b>	permit. Pag Department Important: i any Injury o		4 □ Donetion 5 □ Other (Specify)  21. Signatore of Funerel Service/Occurrence	22. Name	end Address of Facility	5/9/19/1	ansaow	me, Ma.
8	205 29		23a Part VEnter the dispass or complications that sourced the	1050 222	Phu Nort	h Ave. B	eray Mo	.21216
	Physician		23a. Perty Enter the disease, or complications that caused the shock or haert failure. List only ona cause on each line.	beath. Do not enter the m	lode of dying, such es cardi	ac or respiretory errest,		Approximete intarval Between Onset end Deeth
	/Medical Examiner		Immediete Ceuse (Finel disease or condition resulting in daath)	Embolism	Hypote	nsion		5 Hours
		Jer	7. 1 1 Due	to (or es e consaquence o	of):			
	icete be executed physician and s the burial-transit	Examiner	Sequentially list conditions,  Due	to (or es e consequenca o	arombl "		1	
60,	be exe		Sequentially list conditions, if eny, leeding to immediate cause. Entar Undarlying Ceuse (Disaese or injury c.					
68760,	physics tha	Medical		to (or es e consequenca o	f):			
×	laeth certific ettending pl for usa as f		d					
Bo	etter for u	ciar	Dati Oharda Mara					
0	the de by the contract	Physician	Pert II. Other significant conditions contributing to death but not	resulting in the underlying	g cause given in Pert I.		cco use contributa to	
S, P	es thet	by P	2nd Stuge Liver Disea	se		1 Tes	2 No 3 □ Prot	bably 4 Unknown
Records,	law requires thet the deeth certificete be executed as been signed by the ettending physician and a 2 should be deteched for use as the burial-transit	Completed	PenCoraled terminal	ileum		24a. Was en er performed	1? eve	ere eutopsy findings eilable prlor to mpletion of cause death?
Re	0 4 0	Eo				1 ☐ Yes	<b>M</b>	Yes 2 No
Vital	iclan: The cartificate rector, pag	Bec	25. Wes case referred to medical exeminer?		26. Pleca of De	eth (Check only one)		
of V	S 00 0	Jo	Hospital:	2 ER/Outpatient 3 I	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Specify	1)
o u	D a C	:00	27. Manner of Deeth 1 Naturel 5 □ Pending (Month, Day Yea		28c. Injury at Work?	28d. Describe how I	njury occurred	
Division	Attanding or death.	Icati	2 Accidant invastigation 3 Suicide 6 Could not be	M	1 ☐ Yes 2 ☐ No	Opt I costing (Otros	and Markey of Day	10-1-1
Σ	al or Attandir s after daath. al Director: Af ed in by tha fu	Certification:	4 ☐ Homicida datarmined 256. Placa of Injury 1. building, etc. (Sp.	At home, ferm, street, fecto pecify)	ory, office	City or Town, S	t and Number or Rura tate)	r House Wumber,
	split nour y fill	edical	29a. Cartifiar (Check only one)  Cartifying Physician: To the basis of my and menner stated.	knowladga, daath occurra nination end/or Investigetion	d at tha tima, date end place on, in my opinion, deeth occ	ea, and dua to tha ceuse surred et the time, deta	a(s) and manner as steed on the place, end due to	eted. the causa(s)
	To the Ho within 24 I To the Fu completed	M	29b. Signature and the Coertific	2	9c. License number	29d.	Date signed (Month, L	Day, Year)
			1 Milosophe	MD	D0053061	4.4.4	204 17	1999
			30. Neme end eddress of person who completed causa of death	(Item 23e) (Type, Print)	D0053061 n GREENE S	WIR		, ,
AH	(6)		BENJAMIN Philosophs, MD	22 South	h GREEKE S	H. BALLIM	ORE MD	21046
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's \$	ignature	Soud!		,	

SNOT A THE REST OF THE PARTY OF

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death

Month

MAR

MD

4b. City, Town, or Location of Death

Columbia,

3. Time of Death

4c. County of Death

Howard

**Physician** /Medical Examiner **Funeral** Director the Maryland man be notified at Director death with Funeral Herrs ; 21215-0020 þ

"natural", or item potest Example filed within 72 hours after I Hygiene. marked other Peges 1 and 2 should be finent of Heelth end Mental I int: If Item 27 Is marked of of Heelth e

Department of Important: If any Injury or **Physician** /Medical Examiner

= 8

Baltimore, Maryland

physician end the burial-trensit for use as signed by the a peen certificate funeral director, After this

Box 68760 P.O. Records, Division of Vital or Attending Physician: death. s after death filled in by within 24 hours of To the Funeral I Hospital completely the

The lew requires that the death certificate be executed edical Certification: To

12 Be Joseph disease or condition resulting in deeth) Examiner Physician/Medical þ Completed Be 27. Menner of Deeth 1 Neturel 2 Accident

165-05-6522 Usuel Residence of Decedent 10a. Stete 10b. County PA 10e. Street end Number 11. Meritel Stetus 1 Never Merried 2 Married ₩Widowed 4 Divorced Completed Elamantary/Secondary (0-12) 17 Falher's Name (First Middle Last) 20e. Method of Disposition Immediete Causa (Finel Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disaese or Injury that initieted events resulting in death) Last

EVELYN

4e Facility Neme (If not institution, give street and number)

Howard County General Hospital

3 Suicide 4 Homicide 29a. Certifie

(Check only one)

If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Unk • 6. Sex 8. Date of Birth (Month, Day, Year) Days Months Hours 1 M 2 ₩ F Yrs 84 10c. City. Town or Location 10d. Inside City Limits Delaware Yeadon NOYes 2 No 10f. Zip Code 10g. Citizen of What Country? 942 Serrill Avenue 19050 USA 12. Wes Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes No Specify: White Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) College (1-4or 5+) Beauty Shop Beautician 18 Mother's Name (First Middle Maiden Sumeme) Lalli (unk.) Assunta 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Patricia Donatelli / Daughter 9862 Helmwood Court, Ellicott Maryland 21042 20b. Place of Disposition (Name of cemetery, cremetory or other piece) Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Holy Cross Cemetery Yeadon, PA Unk. 21. Signal must Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Fecility
Charles L. Stevens Funeral Home, 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Pert1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failura. List only one cause on aech line. Approximate Interval Between Onset and Death hours CARDIOVASCULAR

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? NSUFFICIENCY 1 ☐ Yas 2 No 2□ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No 1万 Inpatient 2☐ ER/Outpatient 3☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Plece of Injury - At homa, ferm, street, factory, office building, etc. (Specify)

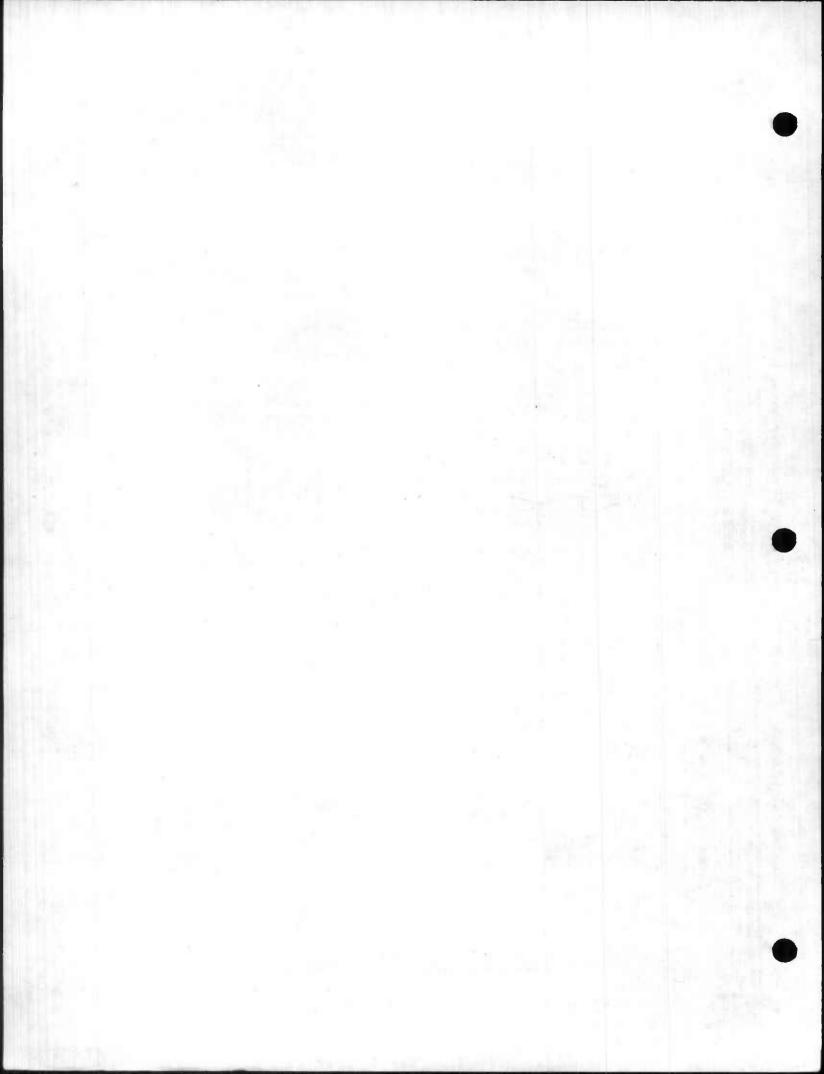
t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end mennar steted. 29b. Signeture end little of certifier-29c. License numbe 29d. Date signed (Month, Day, Year)

Rea MD reactives ATTENDING PHYSICIAN MARYLAND

30. Name and eddress of person who completed causa of death (Item 23a) (Type, Print)

SUITE 300 BALTIMORE, MARYLAND 21229 3449 WILKENS ANCHUE SAFREN MO 32. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM: #31 PER V.R. G769 3-22-99 WR. Certificate of Death 1. Decedent'e Neme (First, Middla, Last) 2. Data of Daath 3. Time of Death Month Pit **Physician** Venable Corine 12.151 1999 /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva straat and number) 4c. County of Deatl **Examiner** CGNTGR MEDICAL BALHMORE LIBERTY If Under 1 Year Months Days Hours Min. 8. Dete of Birth Month, Day, 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 10 M 22 F 69 227-32-932 Usuai Rasidance of Decedent **Director** with the Marylend 10a. Stata 10b. County 10c. City, Town or Location permit. Pages 1 end 2 should be filed within 72 hours effer deeth with the Maryler Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f ahow any injury or other traumatic event, the Mexical Examples must be incitined at once. 10d. insida City Limits BAHIMAK WOODLAWA PETOS 2 No Directo narylono 10e. Street and Number 10f. Zip Coda 10g, Citizen of What Country? RUBB 21207 U5A KERRY 3317 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Meritel Stetus 1 ☐ Yes 2 ☑ No If Yas, Giva Yeer or Detas: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No by Specifyr 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) St. Agnes Hospital Elemantary/Secondary (0-12) College (1-4or 5+) REGISTENED NUISE 4 GARS 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be KINGZELL BRANCH Lucille JACKSON 0 19a. Intormant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 3317 KERRY ROAD MILLARD E. VENABLE BAHHOR, RUZIZOT HUSBBAO 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Burial 2 Crametion 3 Ramovel from Stata -239 CROWE, UIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) JACKSON CEnecky 22. Nama and Addrass of Facility CHATN AN - HARRIS FUNITA Home 21. Signatura of Funaral Sarvice Licensea 52 40 REISTERStown Nomo Balbino18. al 212/1 23a. Part I Entar the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart tellura. List only one cause on each line. Approximata intarvai Between Onset and Death **Physician** /Medical Immediata Ceuse (Finel disaase or condition resulting in death) Examiner Physician/Medical Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Diseese or injury that initieted evants resulting in daeth) Last Division of Vital Records, P.O. Box 68760, Dua to (or es e consequence ot): 88 980 Part ii. Other significant conditions contributing to death but not rasulting in the undarlying cause givan in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown by 24a. Wes en eutopsy performed? 24b. Ware autopsy findings aveilable prior to completion of cause of death? 1 ☐ Yas 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to madical axaminar? 26. Placa of Death (Check only ona) Be Hospitei: 1 Yes 2 No Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 2 1 Unpatient 2 ER/Outpatient 3 DOA After this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of Injury 28c. injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation To the Hospital or Attendir Within 24 hours after deeth. To the Funeral Director: Al 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datamined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of injury - At home, term, streat, tactory, office building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and piace, and dua to tha causa(s) and mannar ss stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the tima, data and piaca, and dua to the cause(s) and mannar stated. 29a. Certifier Medicai 29b. Signatura and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Nems and address of person who completed cause of death (Itam 23a) (Type, Print)

State

31. Deta tiled (Month, Day, Year)

sitat

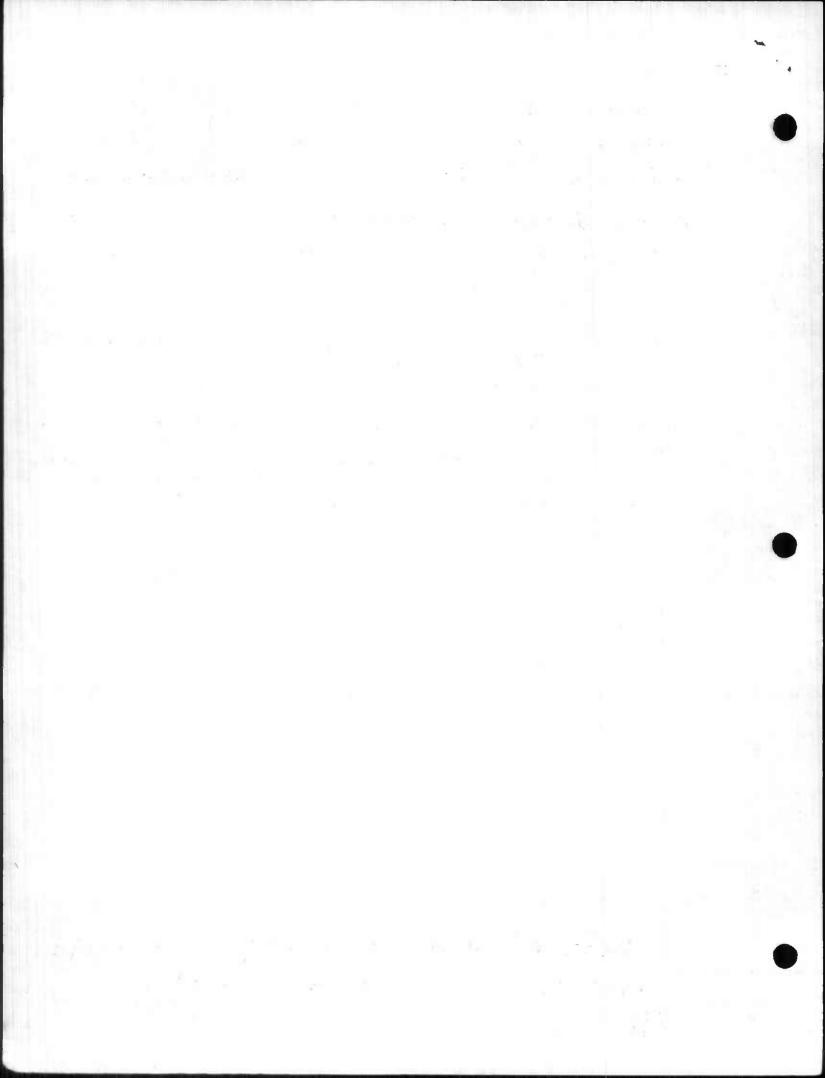
Abousy mo 32. Registrer's Signetura

MAR 2 2 1999

2300

**DHMH 16 Rev 6/95** 

Registrar



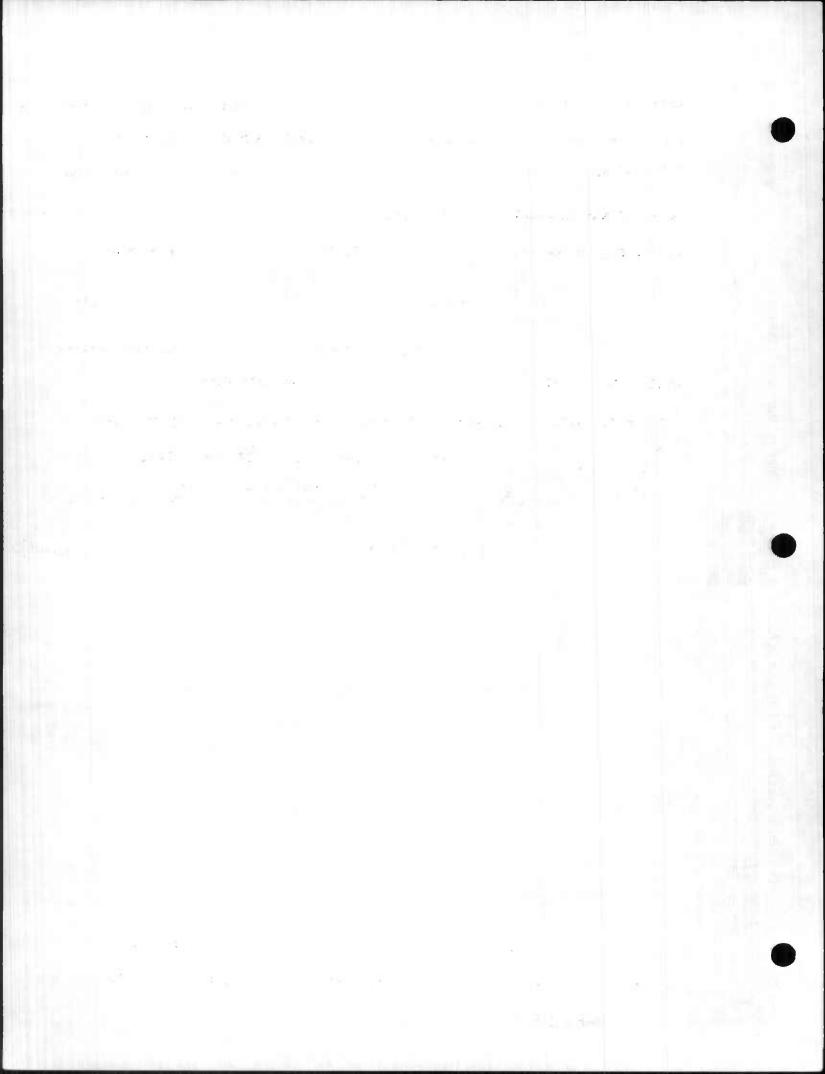
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		State of M	laryland /	Departmer Certificat				giene 9	091	082
	1. Decedent's Name (First, Middle,	Last)					2. Date of De	ath		3. Time of Death
Physician	Charles W. Walls	ace					Month	19, 1999	Year	2:45 P.M.
/Medical Examiner	4a Fecility Name (If not institution,	give street end number,	)			tb. City, Town, or L				
LAdiiiiici	Genesis Elderca	ce - Hammon	ds Lane	9		Brooklyn	Park	Anne	Arunde	21
Funeral	5. Scolal Security Number		ge (in yrs. last	birthday) If Unde	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h v Yearl	9. Birthplac	e (State or Foreign
Director	217-03-8143	1⊠M 2□F	89	Yrs.	Days	riouis wiii.		2, 1910		
natural, or items 23a or 28a-f show uital Evaniner mast be notified at steed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County		100 City T	own or Location					104	. Inside City Limits
of a	Maryland Anne A	cundel		nicum					100	1 ☐ Yes 2 € No
Evanting mast be notified at Evanting mast be notified at by Funeral Director		- unuci	221101		- Oada			10g. Citizen of V	What Causta	
Dir.	10e. Street and Number 803 S. Camp Mead	de Pd			p Code 1090			United		
n 23	11. Meritel Stalus	12. Was Decedent	Ever In II S				necify Yes or No		e - American	
E E	1 ☑ Never Married 2 ☐ Marrie	Armed Forces	?	If Yes, spe	ecify Cub	lispenic Origin? (Si an, Mexican, Puert	o Rican, etc.)	Bled	k, White, etc	
edical Exam leted by F	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2⊠ No	Specify:		Specify	. Wh	ite
Ped Ped	15. Decedeni's	Education		6a. Decedent's Usu	ual Occup	ation		16b. Kind of Bu	usiness/Indus	stry
the Medical	(Specify only highest Elamantary/Secondary (0-12)	grade completed) Collega (1-4or	54)	(Give kind of wo	ork done use retire	during most of world)	king			
r, the Medical	12	College (1-40)	547	Shipping	Cler	k		Shoe Manufacture		
event, Be C	17. Fether's Name (First, Middle, L					18. Mother's Nan		Maiden Sumam	name)	
To	William Henry W	allace				Rosabel:	la Wise			
traumatic event, tr	19a. Informant's Name/Relationsh	p (Type, Print)		9b. Meiling Addres						
other tr	William P. Wall	ace, Jr./Ne		313 Jerly			hicum, M			
or other	20a. Mathod of Disposition 1 Burial 2 □ Cremation	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	20b. Place ceme	of Disposition (Na stary, cramatory or	me of other pla	ce)	Dete March	20c. Location -	City or Town	n, Stete
any injury or once.	4 Donation 5 Other (Spe		Mead	owridge M	iem.	Pk.	23, 199	Elkrid	lge, Ma	aryland
	21. Signalize of Funeral Services, iconsee 22. Name and Address of Facility  Visual days. Payddick Funeral Home. D. A.									
8	Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061									21061
4	23a. Part1. Enter the disaasa, or o shock, or heart failure. List o	omplications that cause	d the death. D	o not enter the mo	de of dyli	ng, such as cardiad	or raspiratory a	rrast,		pproximata iterval Between
ician	or rount value of the	0							C	Onset and Deeth
dical niner	Immediate Cause (Final disease or condition DEMENTIA							14	ss/han 1	
	resulting In death)	d	Due to (or as	a consequenca of)	):					
Examiner	Sequentially list conditions,	b	Due to (or as	a consequenca of)	):					
EX EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.									
the burial-transit	that initiated events resulting in death) Last Due to (or es a consequence of):									
Med as										
for use as										
etached for use a	Part II. Other eignificant condition	contributing to death be	out not resulting	g in the underlying	causa giv	van in Part I.	23b. Did	tobacco uae co	ntribute to ti	he cause of death?
detacl							10	Yee 2 No	3 Proba	bly 4 Unknown
d be det							240 18/00	an autopsy	24h Were	autopsy findings
paga 2 should								ormed?	avalle	able prior to pletion of cause
mpi									of da	ath?
, paga Com							10	Yes 2 No	101	Yas 2M No
ractor, Be	25. Was case referred to medical examiner?	Hospital:			Ott	nor:	ath (Check only o			
P P	1 Yes 2 No	1 Linpeti		Outpatient 3 D	UA	4 LE Nursing H	loma 5 Resi	denca 6 Oth how Injury occur		
funer	1 ⊠Natural 5 ☐ Pending	28a. Data of Inji (Month, Da	ay Year)		28c. Injui		200. Describe	now injury occur	160	
the cat	2 Accident investigation 3 Suicide 6 Could not be determined determined					M 1 Yes 2 No factory office 28f. Location /Street and Number or Rural Route Number				Poute Number
ed in by the funera Certification:	4 ☐ Homicida datarmir	building, e	tc. (Specify)	, reim, street, racto	ry, onica		City or Tol			100,011011001
pelli C	29a. Certifier 1 Certifying	Physician: To the best	of my knowled	foe death occurred	t at the ti	me date and place	and due to the	cause(s) and ma	nnar as stat	ed.
pletely fill edical	(Check only 2 Madical E	caminar: On the basis of and manner si	of examination	and/or investigation	n, in my o	plnion, daath occu	rred at tha tima,	data and placa,	and due to the	ha cause(s)
To the Funeral Director: completely filled in by the Medical Certifical	29b. Signature and title of certifier	^		29	c. Licens	se number		29d. Date signe	d (Month, Da	ay, Year)
	Syry	and			D 40	1491		March 2	2, 199	99
	30. Name and address of person w	ho completed cause of	death (Item 23	a) (Type Print)						
		D. 800 N.			7 Rd	Linthi	cum. Mai	rvland 2	1090	

DHMH 16 Rev 6/95

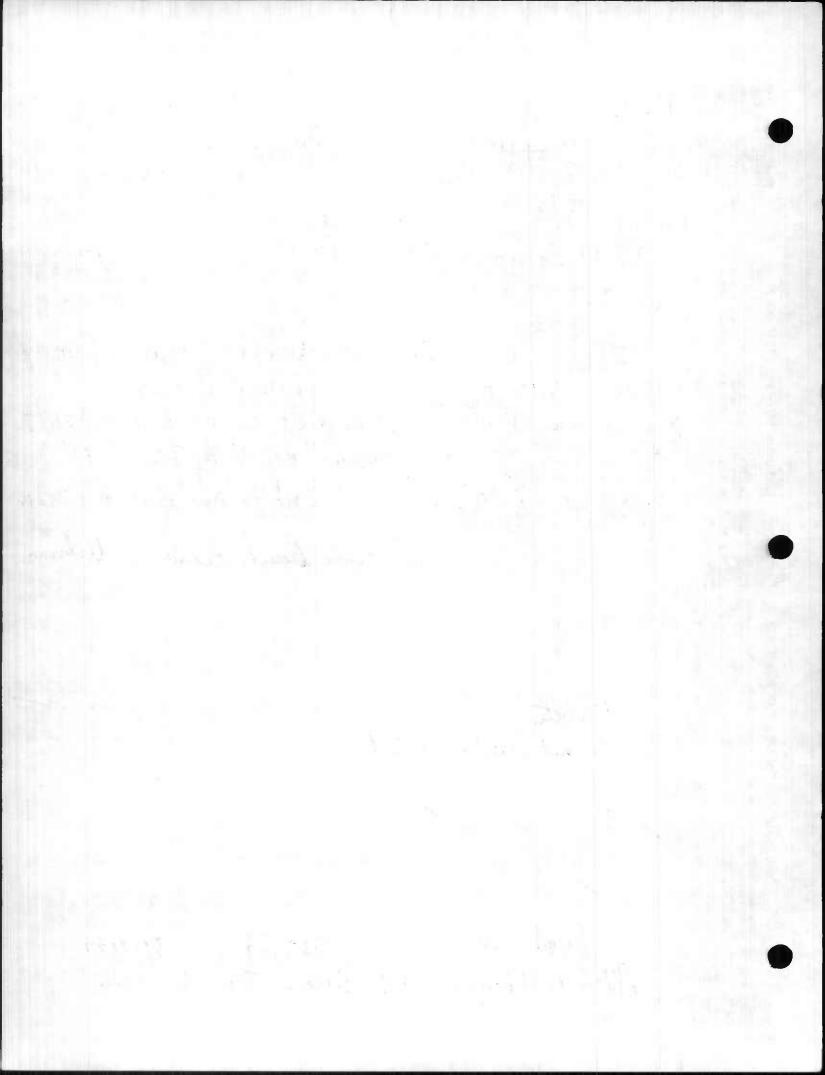
State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signatura



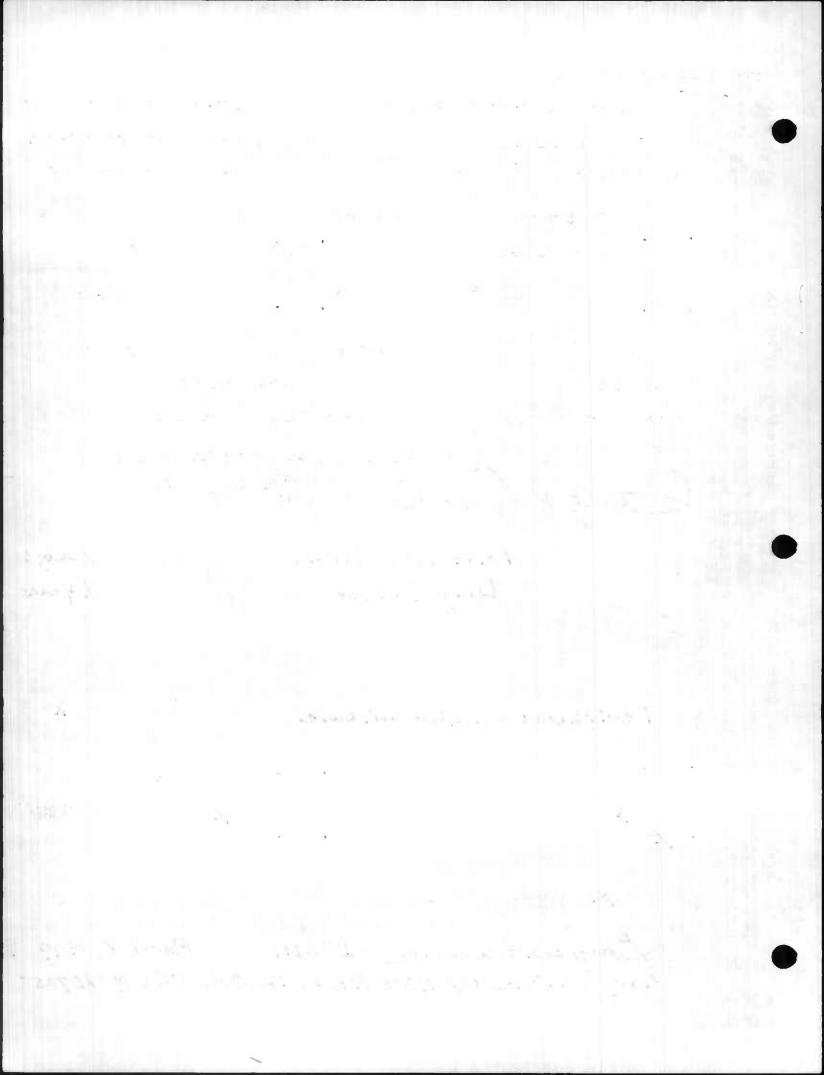
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		State of Maryland /	Certificate of Death	Reg. No.	09003
Physician /Medical	1. Decedent's Name (First, Middla, Last	Nilson		2. Date of Death Month Day Day	3. Time of Death
Examiner	4a Facility Name (If not institution, giva	streat and number)	Dill	Location of Death 4c. Count	A A A
Funeral Director	211-10-7011	X 7. Age (In yrs. lest b)			Mary and
yland	Usual Residence of Decedent  10a. State 10b. County	10c. City, Tov	n or Location		10d. Insida City Limits
vith the Mar to 288-1 all be notified Director	Naryland Number	t Bo	Itimore 101. Zip Code	10g. Citizen of	1 XYes 2 No
3a or 3	2525 W. Be	luedero Au	4. 21215	log. Citizen of	15/7
Baltimore, Maryland 21215-0020 permit. Pagas 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natures", or items 23a or 28a-f show any injury or other traumetic event, ins Medical Examinar must be notified ance.  To Be Completed by Funeral Director	11. Marital Status 1 Never Marriad 2 Married	12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 No If Yes, Give Year or Dates:	13. Was Decedant of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pua	Specify Yes or No- rto Rican, etc.) 14. Ra Bie	ce - Amarican Indian, lick, White, etc.
hours a hours a turnel, o	3 Widowed 4 □ Divorced  15. Decedent's Edu		Decadent's Usual Occupation	16b. Kind of B	Business/Industry
1 21215-0020 eled within 72 hours afrogen young than "natural", or the man wed cell Exem to Completed by F	(Specify only highest grad		(Give kind of work done during most of we life. DO NOT use retired)  OMESTIC WORL	Ker Priva	te Family
and The file and other avent,	17. Fathar's Name (First, Middla, Last)	1000	18. Mother's Na	ame (First, Middle, Meiden Sume	me)
Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic avent	19a Informant's Name/Relationship (7)	po. Pringranddaugh (1)	. Mailing Address (Street end Number or F	Rural Route Number, City or Jown	, Stete, Zip Cope)
re, Maryland 212 1 and 2 should be filed with Health and Mental Hygiens. 6m 27 is marked other than ther traumatic avent, man	20a. Method of Disposition	Jones 5	Strand Ct.  I Disposition (Nama of	Owings Mil	S. Md. 21117 - Gity or Town, State
Baltimore, eemit. Pagas 1 at abortant of them mortant if them my Injury or other mice.	1 Buriai 2 Cremation 3 F	Removal from State	ny, crematory or other place)	3/23/99 Bal	to, Md.
Baltimoperant: Pag Department Important: I eny Injury o	21. Signature of Funeral Service Ocens	· 9 4	22 Name and Address of Facility	iss Funer	al Home
	23a. Part V Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. Do	not anter tha mode ot dying, such as cardii	ac or raspiratory arrast,	Approximete Interval Between
Physician /Medical	Immediate Ceuse (Final		_ 1	1 Siene	Onset and Death
Examiner	disease or condition resulting in death)	Due to (or as a	consequence ot):	distant	With the last
awcuted n and ial-transit	Sequentially list conditions,	b Due to (or as a	consequenca of):		
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that inflated events	c			
W =	resulting in death) Last	Dua to (or as a	consequence of):		
P.O. Box ( at the death certif t by the attending etached for use a	Part II. Other significant conditions con	ntributing to death but not resulting	n the underlying cause given in Part I.	23b. Did tobacco use co	ontribute to the cause of death?
IS, P.O. Box es that the death cert igned by the attendin be detached for use by Physician/N	Trubete			1 ☐ Yes 2 ☐ No	3 Probably 4 Unknown
ord requir seen s hould	Cerebrul	vascelar axi	Sent	24a. Was an autopsy performed?	24b. Were autopsy findings svaliable prior to completion of cause of death?
Vital Recsition: The law so cardificate has birector, page 2 s				1 ☐ Yes 2 No	1 Yes 2 No
f Vital Resident That is cartificate he director, page	25. Was case referred to medical exeminer?	Hospitel:	Othor	eath (Check only one)	
on of Valing Physic h. After this of funaral direction: To	27. Menner of Deeth	1 LI Inpatient 2LEFER/O	time of linjury et Work?	Home 5 Residence 8 Of	
Division c tal or Attending P is after death. In Director: After t ed in by the funera Certification:	1 €Natural 5 Pending 2 Accident Investigation 3 Sulcida 6 Could not ba	28e. Placa of Injury - At home, f	M 1 Yes 2 No	28f. Location (Street and Num	nher or Bural Boule Number
Div.	4 Homicide determined	building, etc. (Specify)	arm, street, factory, office	City or Town, State)	Del of flatal floore statistics,
Division or To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After this completally filled in by the funeral Medical Certification: 1	29a. Certifier 1 Certifying Phy. (Check only one) 2 Medical Example	sicfan: To the best of my knowledg ner: On tha basis of axemination a and mannar stated.	e, death occurred at the time, date and plan nd/or investigation, in my opinion, deeth occ	ca, and due to the cause(s) and mourred at the time, date and placa	nanner as stated. , and due to the cause(s)
To the comple	29b. Signature and title of warmer	F .	29c. License number	29d. Date sign	ed (Month, Day, Year)
	/VICEN	10	12756	7 31	19199
A4(3)	30. Nama and address of person who d	Impleted cause of death (Item 23a)	X36 (Keen	Thee Red #	300
State Registrar	31. Date filed (Month, Day, Year) MAR 9 9 10	32. Registrar's Signature	b. books		



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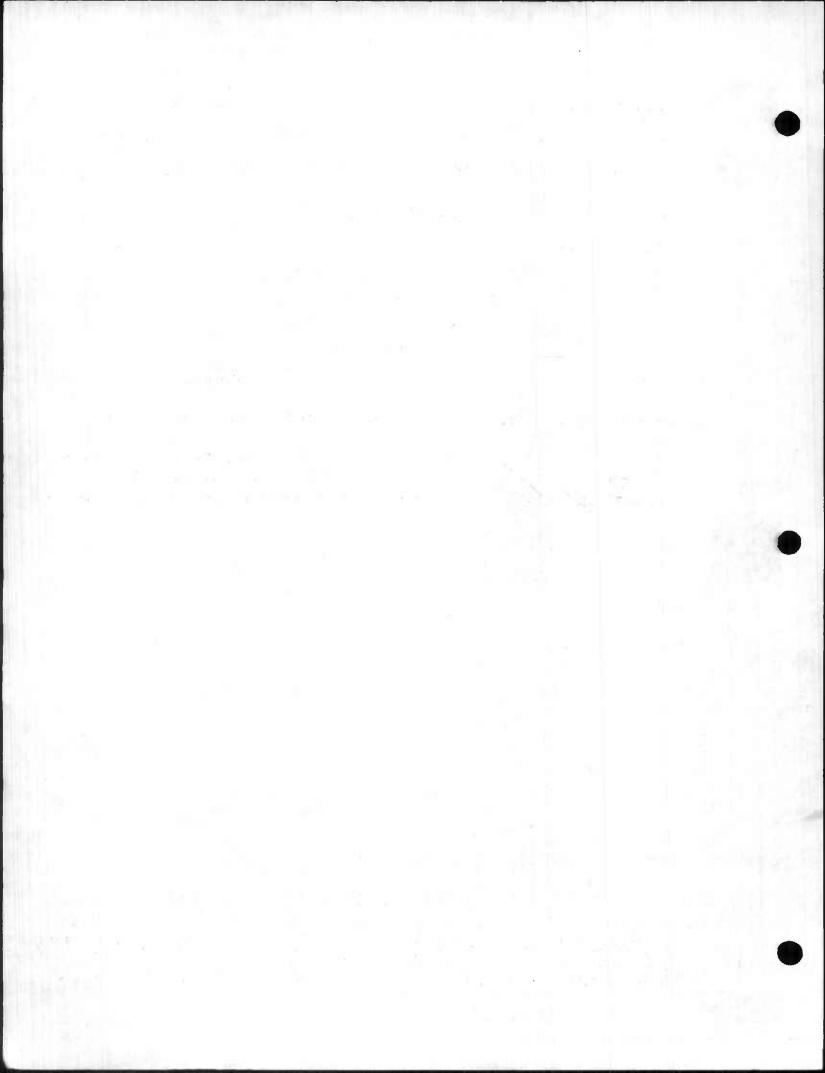
TEM: #26_PI	R MD G769 3-22-		4		Certificate of	f Death		leg. No.	UJ	UBU	
Physician /Medical	1. Decedent's Name (Firs		HEBRON	WALL	ACE		2. Data of Dea Month MARCH	5, 19	Yaar	3. Time of Death LO:40 PM	
Examiner	4a Facility Nama (If not in	stitution, give	street and number)			4b. City, Town, or	Location of Death	4c. County of	of Death		
		oth St			M.Hda-A.Wa-	N. Bre				SEORGES	
uneral rector	5. Social Security Number 216-22-356	50 11	TM STE	(In yrs. last bir	thday) If Under 1 Yaa Months Dey			, 1929	9. Birthplace Country Mary	ce (State or Foreign 7) 1)	
rai Director	Usual Residence of Dece 10a. State 10b.	County		10c. City, Tow	n or Location				10d	I. fnside City Limits	-
5	MD Ba	altimo	ore	В	altimore					1 ☐ Yas 2X No	ı
il Director	10e. Street and Number 1517 Let	mon St	reet		10f. Zip Code	21223	1	0g. Citizen of W	hat Country	/?	
by Fune	11. Maritai Status 1 Never Married 2 3 Widowed 4 D		12. Was Decedant E Armed Forces? 1  Yes 2 No. If Yes, Give Year or Datas:		13. Was Decedant of if Yas, specify Cu		Specify Yes or No- no Rican, etc.)		- American c, White, etc	o	
Be Completed	(Specify onl		ucetion de completed) College (1-4or 54		Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	upation a during most of wo red)	orking	16b. Kind of Bus			
8	Sth 17. Father's Name (First,	Middle ( set)			Packer	18 Mother's No	me (First, Middle,			J •	1
To Be	William					Eva	Matthe	ws			
	19a. Informant's Name/R Cora Smitl			196	. Mailing Address (Stre 521 Banne	er St.,	N. Bren	twood,	State, Zip C MD 2	20722	
important: if them 27 is marked other than any injury or other traumetic event, the 18 once.  To Be Comp	20a. Method of Disposition  1 🗷 Burial 2 □ Created a □ Donation 5 □ Company  1. Signature of Funeral States	mation 3 D Other (Specify		cemete	Nat'l Mem  22. Name and Add SNOWDEN	n. Park	3/11/99				
5 6 8	23a. Part1. Enter the disc shock, or heart failu	E K	Rications that causad i	tha death. Do	ROCKVILI	E, MD	20350		A	pproximate	
iclan	shock, or heart failu	List only	ona chusa on each line	э.			,		tr	nterval Between Onset and Death	i
lical iner	Immediate Cause (Final disaasa or condition resulting in death)		. Pula	nonai	ry Ede	ma			- 6	2 days	l
nsit		-	b. Lu	ng (	ancer				ó	2 years	ļ
for use as the bunel-transit	Sequentially list condition if any, leading to Immedia ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ate	C		consequence of):			-			
by Physician/N	Part li. Other signiffcant (	conditions or	d	not resulting i	n the underlying cause.	given in Pert I	23b Dfd t	ohacco usa con	tribute to ti	he cause of death?	
by Physician/M	0				Disea				3 Probe		
eted							24a. Was a	an autopsy med?	avail	e autopsy findings able prior to pletion of ceuse ath?	
Comp						4 ,	1 🗆 Y	es 2 No	10	Yes 2□ No	-
director, page 2	25. Was cese referred to examiner?						eath (Check only or	78)		Connection	1
٥ di	1 ☐ Yas 2 No			t 2 ER/O	stpatient 3LI DOA		Homa Mosid			Granddaughte House	-
he funera	2 Accident	Pending Investigation		Year) 28b.		jury at /prk? ☐ Yes 2 ☐ No	28d. Describe h	ow Injury occurre	ed		
Completely filled in by the Medical Certifical	3 ☐ Sulcide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, fa (Specify)	ırm, street, factory, offic	29	28f. Location (5 City or Tow	itreet end Numbern, State)	er or Rurel I	Route Number,	
completely filled in by the funeral dira				examinetion an	e, death occurred at the d/or investigation, in my						
Com	29b. Signature and title of	certifier 2c	Ane	50		30111		29d. Data signed March			
	30. Name and address of	W. J		eth (Item 23a)	200 0.6	ea Dr	Belts	s:lle	Mdi	20705	
State Registrar	31. Date filed (Month, Day	r, Year) R 2 2 19	32. Registra	r's Signatura	1. Spor	Kal					



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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death **Physician** MOB/17/99 2:30 AM Elva Mae Weddell /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Daath Examiner Baltimore Towson Genesis Multi Medical center Towson 5. Social Sacurity Number If Undar 1 Yaar if Undar 24 Hrs. 8. Data of Birth Month, Day, Year) 02/16/1931 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Days Hours 1□ M 22 F 68 220-28-3337 Yrs Director Maryland Usual Rasidance of Decadant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD N/A Baltimore Director 1 A Yas 2 No 10e. Street and Number 10g. Citizen of What Country? U.S.A. 10f. Zip Coda 6 6011 The Alameda 21239 Items 23a death 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 14. Raca - Amarican Indian, Black, Whita, atc. 11. Maritai Status Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 72 hours after 1 □ Navar Married 2 □ Married permit. Pages 1 and 2 should be filed within 72 hours att Department of Haaith and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any Injury or other traumatic event. White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 A No Specify: À 3 ₩ Widowad 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Dacadent's Education 16b. Kind of Business/Industry (Spacify only highast grada complatad) Elementery/Secondary (0-12) College (1-4or 5+) Nursing Aide Shepard Pratt 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Surnama) Be Alvin W. Burns Sr. Lucy Elizabeth Casey 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Arville L. Weddell Jr. 6011 The Alameda Baltimore, Maryland 21239 20b. Placa of Disposition (Nema of camatary, crematory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 3/19/99 Baltimore, Maryland Glen Haven Cemetery 22. Nama and Addrass of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Entar tha disaasa, or compu-shock, or heert feilura. List only from that causad tha death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, causa on each line. **Physician** /Medical Immediate Causa (Final disaasa or condition rasulting in daath) Examiner Examiner Kin Soni Sm Hospital or Attending Physician: The law requires that the death certificate be associted As bruns after of death.
 Funeral Director: After this certificate has been signed by the attending physician and elety filled in by the funeral director, page 2 should be deteched for use as the buntal-transit attending physician and I for use as the bunal-transit Sequantially list conditions, if any, laeding to immediata cause. Enter Underlying Causa (Diseesa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24a. Was en autopsy performad? 24b. Wera autopsy findings avellebla prior to complation of causa of daath? 1 Yas 2 No Division of Vital Be 25. Was casa refarred to medical 26. Placa of Daath (Chack only ona) Hospitai: 1 ☐ inpatiant 2 ☐ ER/Outpatlent 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 28a. Data of injury (Month, Day Yaar) 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury et Work? 5 Panding invastigation 1 Naturai 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Pleca of injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicida within 24 hours a To the Funeral D 29a. Certifian Tertifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and due to the causa(s) and manner as stated. Destriying Physician: 10 tha best or my knowledge, death occurred at the time, data and place, and due to the deduction of the basis of examinetion and/or invastigetion, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. To the 29b. Signeture and title of certific 29c. Licansa number 29d. Data signed (Month, Day, Year) D18186 30. Name and address person who complated causa of death (item 23e) (Type, Print) UXWOOD Rd Balto MD 2120 780 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State Registrar

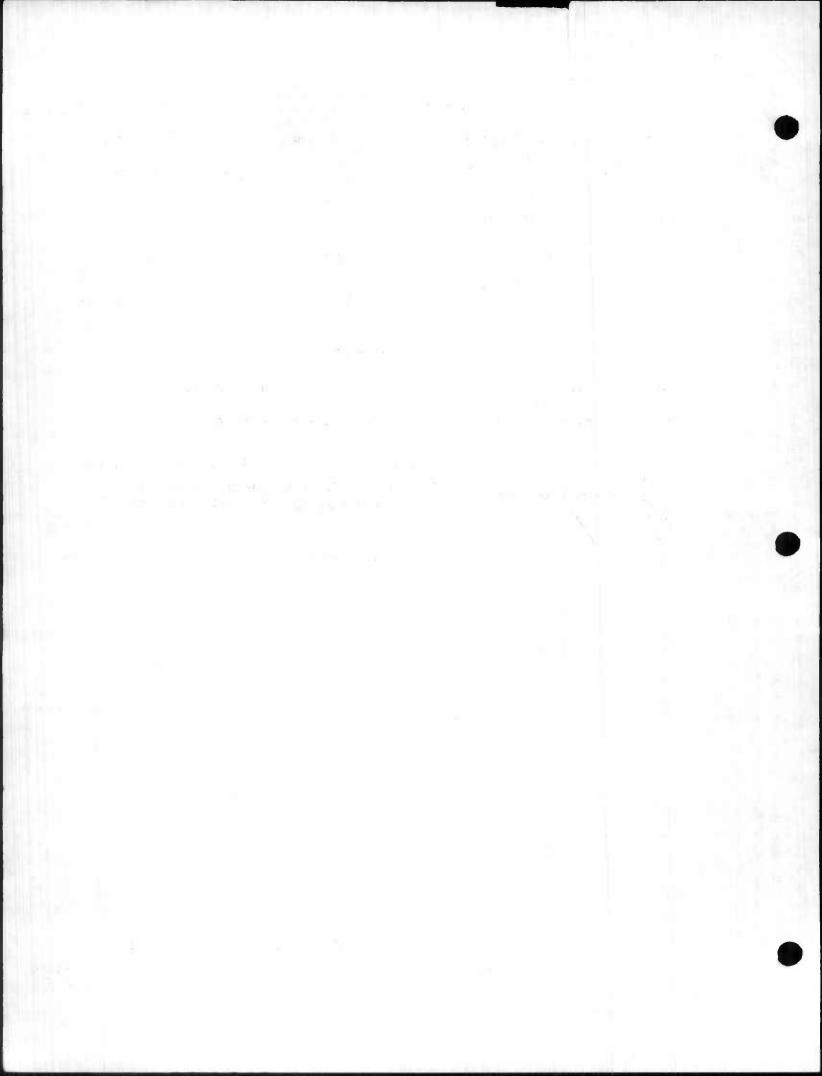


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State of Maryland / Department of Health and Mental Hygiene

				Ce	rtificate of	f Death	Re	g. No.		
Phys	ician	Decedant's Nama (First, Middla, La	•				2. Data of Death	Day	Yaar 3	3. Tima of Death
	dicai	Jeanette	Zimmerm	an			DARCH	17	1999	3:23 PK
Exan	niner	4a. Facility Nama (If not institution, gir Doctors' Commun	ity Hospital			4b. City, Town, or Loc Lanham	ation of Death	4c. County	e Geor	0
Funer Directo		052 05 2375	Sax 7. Aga (In yrs.	last birthday, Yrs.	Months Day	s Hours Min.	8. Data of Birth (Month, Day, Sept. 15	Year) 5,1917	9. Birthplace Country) Mary 1	a (Stata or Foraign and
pu *		Usual Rasidanca of Dacadant  10a. Stata 10b. County	10c Ci	ty. Town or L	ocation				104	Insida City Limits
Maryle Maryle	ector	Maryland Prince		owie						t∕CXYas 2 No
death with the A	Funeral Director	10e. Street and Number 8910 Harness Wa	,		10f. Zip Coda 2071	.5	J	United	What Country? States	
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydjens. Important: If them 27 is marked other than "natural", or thems 23s or 28s-f show any Injury or other traumatic event, the Medical Evanmer must be notified as	b	11. Marital Status 1 Navar Married 2 Married 3 YWidowed 4 Divorcad	12. Was Dacedant Evar in U Armed Forcas? 1 ☐ Yas 257No If Yas, Giva Yaar or Datas:		Was Dacedant of If Yas, specify Cu 1 ☐ Yas 3 ☐ No	Hispanic Origin? (Speciban, Maxican, Puarto R	ify Yas or No- lican, atc.)		a - Amarican I ck, White, atc. :: Whit	
5-0 72 ho	etec	15. Dacedant's E (Spacify only highast gr	ducation ada complatad)	18a. Dece	dant's Usuai Occi	upetion e during most of working red)	0 1	6b. Kind of Bu	usinass/Indust	ry
Maryland 2121 d 2 should be filed within the and Mentel Hygiene. T is marked other than traumatic event, the tea	Completed	Elementery/Secondery (0-12)	Coilege (1-4or 5+)		DO NOT usa retir Bindery	•		I.S. Go	vernme	nt
d 2 d		17. Father's Nama (First, Middla, Last	<del>-</del>			18. Mother's Nama				
lan	To Be	Peter Bacinski				Sophie 1			,	
ary shou	-	19a. informant's Name/Ralationship	Type, Print)	19b. Maili	ng Address (Stree	et end Number or Rural		_	Steta, Zip Co	da)
M, M		Byron Zimmerman	Son	891	0 Harnes	s Way Bowi	e Maryla	and 207	15	
more rages 1 and of He is if He in y or oth		20a. Mathod of Disposition  1 ☐ Burial 2 🖾 Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	JHamovai from Stata		osition (Nema of matory or other pi	I I			City or Town,	
Baltimore, permit. Pages 1 er Department of Heal De	Suce	21. Signatura of Funaral Sarvice	TIEL	- <sup>2</sup>		rass of Facility . Evans Fur		me, In	с.	
		23s. Part . Enter the disease for com	plications that caused the deal	th. Do not en	16000 And	napolis Rd.	Bowie M	arylan		5 proximete
Physicia	n	23a. Part . Enter the disease or com shock, or heart failure List only	ona ceusa on aach lina.			,		- 1,	Inte	arval Between sat and Death
/Medica	al .	Immediata Causa (Final disease or condition	agna	enor	no for	wel				An.
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68760, ificeta be axa g physician e		Sequantially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disass or Injury that initiated evants								
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. Box death cert e attendin d for use	cia	Part II. Other significant conditions of	contributing to death but not res	culting In the u	Indertying cause of	riven in Part I	23h Did tol	Secon Hee con	ntribute to the	e cause of death?
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aw requi	Completed by			•			24a. Was an perform		availab	autopsy findings bla prior to ation of causa th?
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f Vital I ysicien: The s certificate director, pag	Be	25. Was case refarred to medical axaminar?				26. Placa of Death	(Check only one	)		
Of \Physic ral direction	2	1 M Yes 2 □ No		ER/Outpatie	IN SLI DOM	ther: 4 Nursing Hom				
OD O	lon:	27. Manner of Death  1 ☑ Neturei 5 ☐ Panding	28a. Data of Injury (Month, Day Year)	28b. Tima o Injury	W		8d. Dascribe hor	w Injury occur	ed	
Visic Attend ar death ector: by the	Certification:	2 Accident Invastigatio	e 28a. Pieca of Injury - At h	oma, farm, st		Yes 2 No	3f. Location (Str.	aet and Numb	er or Rural Ro	oute Number,
Div s after il Dire	Sert	4 Homicida dataminad	building, atc. (Spacil	(y)			City or Town,	Stata)		
Divisio  To the Hospital or Attendi vitini 24 hours after death. To the Funeral Director: A completely filled in by the fo	edical (	29a. Cartifier 1 Cartifying Pt (Check only one)	nyaiclan: To the best of my kno ninar: On the basis of axamine and mannar stated.	owladga, daat ati <i>on</i> and/or In	h occurred at the vastigation, in my	tima, data and placa, ar opinion, daath occurred	nd dua to tha ca d at tha time, da	use(s) end ma ta and place,	nnar as stated and dua to tha	d. i cause(s)
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		30. Neme and addrass of person tho	completed cause of daath (Iter	n 23e) (Type,	Print) 721 BD7	LE POIM	r DRIVI	GRI	FINRE	2077C
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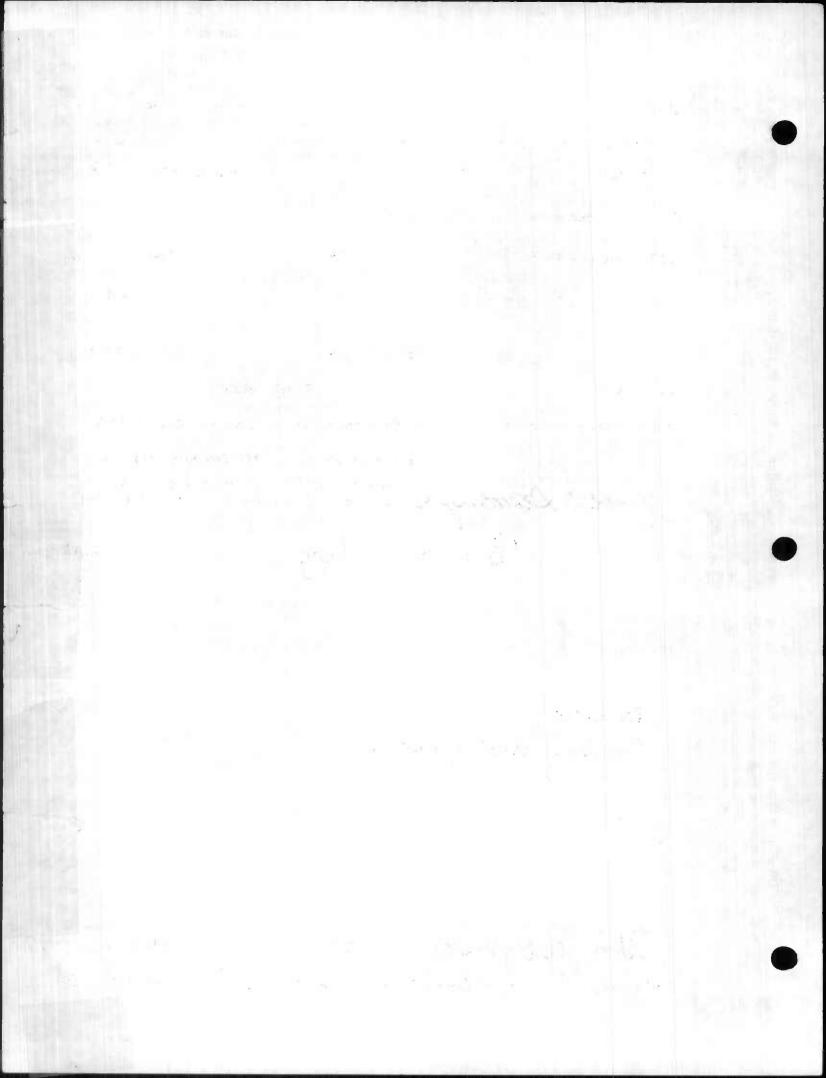
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State of Maryland / Department of Health and Mental Hygiene (

Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) **Physician** March 10, Elvin Adams 1999 5:00am /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) **Examiner** Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Yeer If Under 24 Hrs. 8. Data of Birth (Months, Dey, Year) Feb. 9, 19 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country)
New Jersey **Funeral** Months 1☑ M 2□ F Yrs. 091-05-2074 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. inside City Limits "natural", or items 23a or 28a-f ahow MD Montgomery Rockville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 6121 Montrose Road 20852 USA death Funeral Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 12. Was Decedant Evar in U,S. Armed Forces? 11. Maritel Status Bieck, White, etc. filed within 72 hours aftar 1 Yes 2 No If Yes, Give Yaar or Datas: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3₺ Widowed 4 Divorced the Medical Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Hygiena. Elamentary/Secondary (0-12) College (1-4or 5+) Guidance Counselor Public Schools 5+ merked other permit. Pages 1 and 2 should be file Department of Haalth and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event page. 18. Mothar's Name (First, Middle, Meiden Sumama) 17 Father's Neme (First, Middle, Last) Be Wolf Adams Ethel (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19e. Informent's Neme/Reletionship (Type, Print) 11905 Bristol Manor Ct N Bethesda, MD 20852 Lauren Thomas-Daughter 20b. Plece of Disposition (Neme of cematery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State B/11/99 Rockville, MD Parklawn-Menorah 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility Danzansky-Goldberg Memorial Chapels, Inc 21. Signeture of Funeral Service License 1170 Rockville Pike; Rockville, MD 20852 23a. Pert1. Enter the disease, or complications that caused the shock, or heart feilure. List only one cause on each line. eth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** unknown /Medical Immediate Cause (Finel disaese or condition resulting in deeth) Examiner Due to (or es a consequence of) Examiner end I-transit The law requires that the daeth certificate be axecuted Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted avants Due to (or as a consequenca of): physicien e Division of Vital Records, P.O. Box 68760, Physician/Medicai that initieted avants resulting in deeth) Lest Dua to (or as e consequenca of) for usa es Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the hed signed by t 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No by 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24e. Was an eutopsy performed? Completed artery Disease peed cartificate hes t 1 Yes 2 No 1 ∏Yes 2 ∏ No or Attending Physician: director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Aftar this funaral 28e. Date of Injury (Month, Dey Yeer) 27. Manner of Deeth 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No I Director: Af death. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, farm, street, fectory, office building, etc. (Specify) To the Hospital or A within 24 hours effer To the Funeral Directorn pletaly filled in by 4 Homicide efter 29a. Certifian id Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) and manner es steted Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end pleca, end due to the cause(s) end menner steted. 29d. Date signed (Month, Day, Year) 29b. Signatury And title of certifie 29c. License number 30. Name end eddress deeth (Item 23e) (Type, Print) Montrose Rd Rockville, MD 20852 CHIEFORY 6121 31. Dete filed (Month, Day, Year) . Registrar's Signature State 1999 MAR 1.2 Seper Registrar



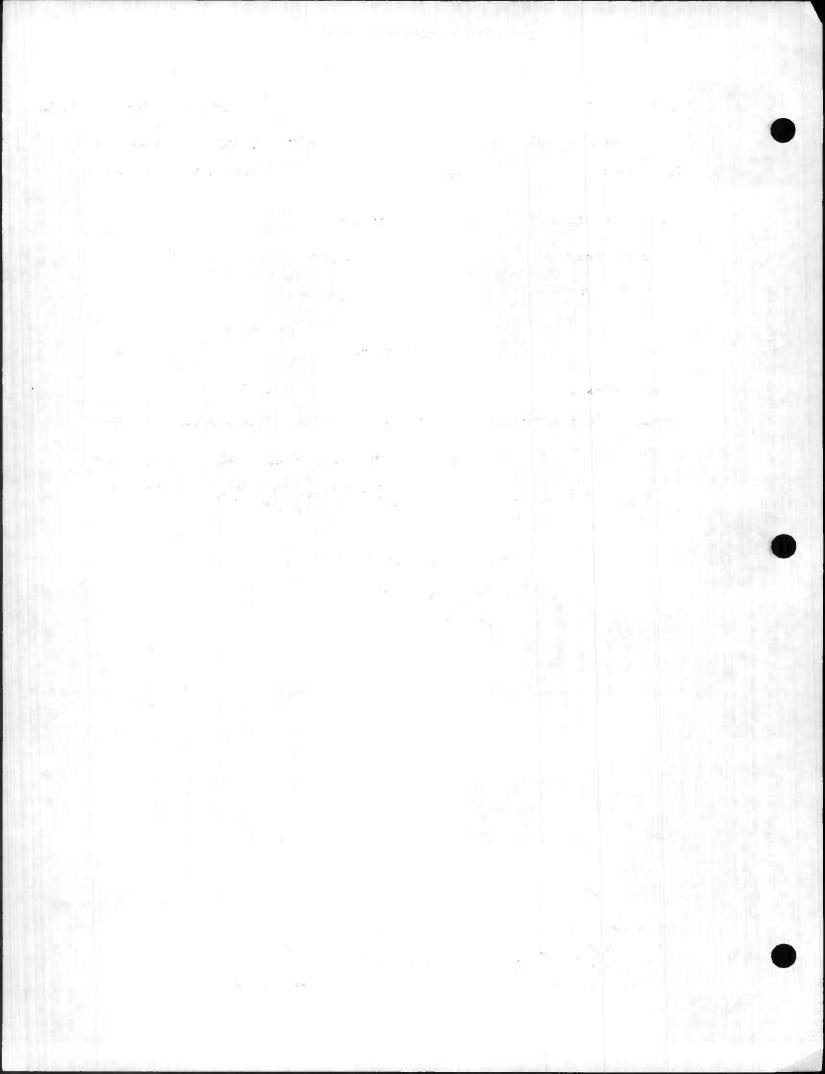
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State of Maryland / Department of Health and Mental Hygiene \( \text{Q} \)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Marilyn J. Adrian 8. March 1999 3:55 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street end number) 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
March 4, 1935 5. Social Security Number 9. Birthplace (State or Foreign Country) New York 7. Aga (In vrs. last birthday) **Funeral** Months 1 M 2 X F 099-28-4511 Yrs. 64 **Director** Usual Residence of Decedent with the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 ☐ Yes 2€ No Directo Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumstic event, the Medical Examiner must be a 12543 Heurich Road 20902 USA permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or flems 23s any injury or other traumatic event, the Ned Funerai 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, atc.) 14 Race - American Indian Black, White, etc. 1 ☐ Naver Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middle, Last) Herman Potratz Mary Griffin 19b. Mailing Addrass (Straet and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James C. Adrian/Husband 12543 Heurich Rd., Silver Spring, MD 20902 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemet. 3/15/99 Arlington, VA 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd. West
Silver Spring, MD 20901

23a. Parti\[Collins = 1 \]
23a. Parti\[Collins = 1 \]
25a. Parti\[Collin Approximata tnterval Between Onset and Death **Physician** /Medical fmmediate Cause (Final 8 years disaasa or condition rasulting in daath) Examiner Examiner 2003.5 physician and s the buriel-transit that the death certificate be executed Sequentially list conditions, if any, laading to Immadiate ceusa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Scheroder Division of Vital Records, P.O. Box 68760, Years Physician/Medical Dua to (or as a consequenca of): ettending ph signed by the e Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? should 24a. Was an autopsy performed? Completed page 2 s 1 Yas 2 Phin 1 Yes 2 9 No certificate or Attending Physician: funeral director, Be 25. Was cese referred to medicet examiner? 26. Place of Daath (Check only one) Other: 4 Nursing Home 5 Rasidance 8 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of tnjury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Matural 5 Pending death. 1 Yes 2 No Investigation 2 Accident 24 hours efter deat Funeral Director: 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) à 4 I Homicide filled in I Hospital 1 Certifying Physician: To tha bast of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated. 29a. Certifier within 24 hor To the Fune completely fi edicai 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 9.1999 Morch eins 12457 0 30. Nama and address person who complated ceusa of daeth (Item 23a) (Type, Print) Weiner 11501 Georgia 31. Date filed (Month, Dey, Yeer) MAR 12 1999 32. Registrar's Signature State Deperson Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Annie Ross Anderson 5, March 1999 10:30 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare - Layhill Center Silver Spring Montgomery If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Davs Min. Months 1□M 2☑F Yrs Director 220-38-2868 Sep. 26, 1909 Virginia Usuai Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death Funerai 214 Normandy Drive 20901 USA 14. Race - American Indian, or Nerra 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merilei Stelus Black, White, etc. 72 hours after 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. P 3 ☑ Widowed 4 ☐ Divorced White "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) other 1 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: if Nem 27 Is marked oth any Injury or other traumatic event Macs. Be 0 Daniel Nuckols Sadie Hubbard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha A. Coon 7905 Briarheath Court (daughter) Gaithersburg, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donelion 5 ☐ Other (Specify) Parklawn Memorial Park 03/9/99 Rockville, Maryland 21. Signeture of Funeral Service Lipensee 22. Name and Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or conditio resulting in death) a Cerebrovascular Arteriosclerosis Examiner 10 years Due to (or as a consequence of): Examiner burial-transit that the death certificate be asscuted and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medicai the Due to (or es a consequence of): attending p 88 ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 0 1 Yaa 2 No 3 Probably 4 Unknown 0 signed b Division of Vital Records. py been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 1 Yes 2 No certificate 1 TYes 2 No or Attanding Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2⊠ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attandir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

United Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) U D 12121 March 8, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George F. Sengstack, 3929 Ferrara Drive M.D. Wheaton, Maryland 20906-4709

**DHMH 16 Ray 6/95** 

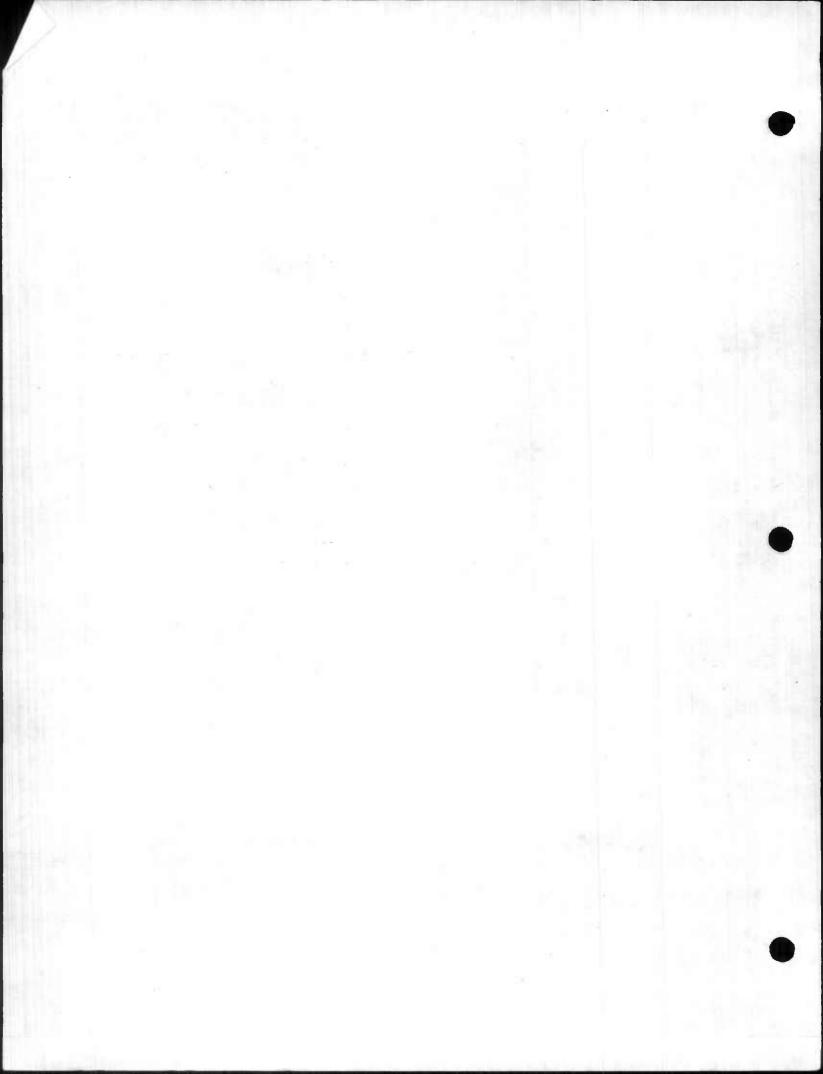
State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 9 1999

32. Pegistrar's Signature



Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

TIE MO

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29c. License number

29d. Date signed (Month, Dey, Yeer)

CLOVERLY ST. SILVERSPRING ND 20905

MARCH 5, 1999

Medical completely To the within 2 To the

> State Registrar

29a. Certifier

(Check only one)

JOHN E 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

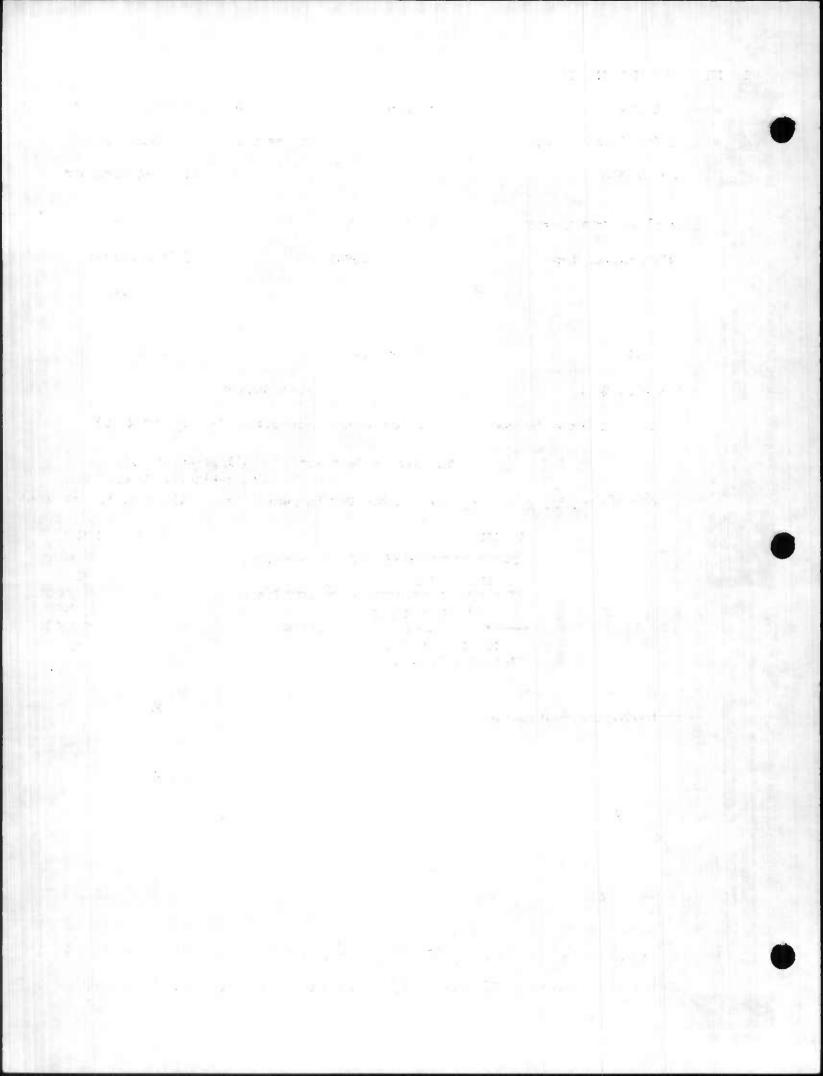
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32. Registrar's Signature

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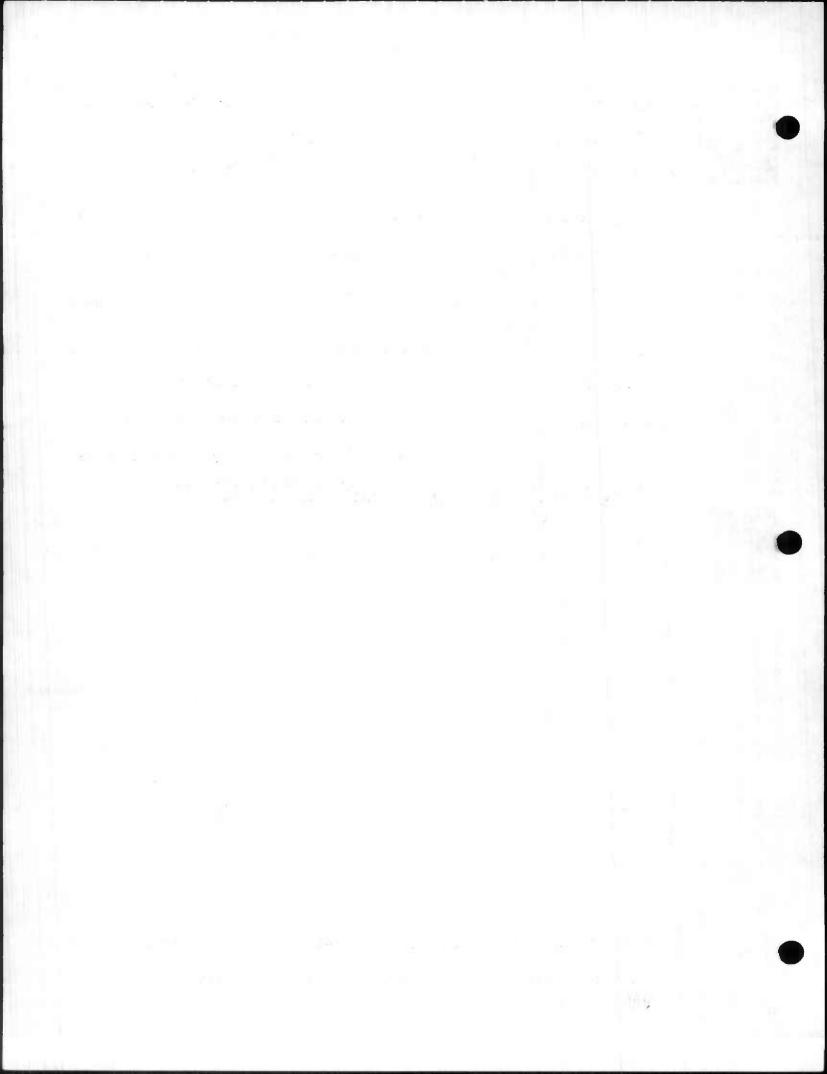
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MAR 0 8 1999



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1.54					iai y iai		tificate of	Death		Reg. No.		
ı	Physic	an	Decedent's Name (First, Middle, Las  IVAN LEE ARE	1)					2. Date of Dea Month	6, Del 1999 Ye	3. Time of Death 12:30 am	
d	/Medi Exami		4a. Fecility Neme (If not institution, give	street and number	)			4b. City, Town, or L		_		
			12015 MCGEE LAN					CUMBERLA		ALLEGA	NY	
	Funeral Director		213 20 0700	X 7. A ⊇M 2□ F	ge (In yrs. 66	last birthday) Yrs.	if Under 1 Year Months Days					
	ylend		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo					10d. inside City Limits	
	r 28a-f show	ctor	MD Allegany	,		Cumber	cland				1Ă Yes 2□No	
	23e or 2	Funeral Director	10e. Street and Number 12015 McGee Lane				10f. Zip Code 2150	)2		10g. Citizen of Whe USA		
020	72 hours after death with the Marylend nature!', or items 23s or 28s-f show doel Examinet must be notified at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Å Yes 2 ☐ If Yes, Give Year or Dates:	No		Was Decedent of I Yes, specify Cut I ☐ Yes 2 No	Hispanic Origin? (Spoan, Mexicen, Puerto Specify:	ecify Yes or No- Ricen, etc.)	14. Race - A Bleck, V Specify:		
21215-0020		Completed	15. Decedent's Edi (Specify only highest grad	cetion le com <i>pleted)</i> College (1-4or	5+)	16a. Deced (Give life. L Retire	lent's Usual Occu kind of work done DO NOT use retire ed Machi	pation during most of work ed) nist			200 Year 12:30 am  County of Death LEGANY  9. Birthplace (State or Foreign CMD)  10d. Inside City Limits 12 Yes 2 No en of Whet Country? USA 4. Race - American Indien, Bleck, White, etc.  Specify: white d of Business/Industry  12:30 am  10d. inside City Limits 12 Yes 2 No en of Whet Country? USA 4. Race - American Indien, Bleck, White, etc.  Specify: white d of Business/Industry  12:30 am  10d. inside City Limits 12 Yes 2 No en of Whet Country? USA 4. Race - American Indien, Bleck, White, etc.  Specify: white d of Business/Industry  12:30 am  10d. inside City Limits 12 Yes 2 No  10d. inside City	
nd 2	o filed within al Hygiene. I other than want, it want	Be Co	17. Father's Name (First, Middle, Last)						e (First, Middle,	Maiden Sumame)	, , , , , , , , , , , , , , , , , , , ,	
Maryland	d 2 should be fill and Mental H 7 is marked oth traumatic even	To	Clayton Abe			T			(Buckle			
	nd 2 sh lith and 27 is n r traun		19a. Informent's Name/Relationship (T) Edna Abe—wife									
Baltimore,	pernit. Pages 1 end 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic evant, once.		20a. Method of Disposition  1		20b. F	Place of Dispo- cemetery, cren Vis Mer	sition (Name of natory or other pla norial C	emetery	Dete 03/09			
Balti	permit. Pa Depertmer Important: any injury once.		21. Signature of Fuperel Service Licens	1. Ma	100	M. 22	Name and Adda Scarpel Cumber]	11 Funera	1 Home, 21502	P.A.		
			23a. Part1. Enter the diseese, or complete shock, or heert failure. List only of	icalions that cause	d the deat	h. Do not ente	er the mode of dy	ing, such as cardiec	or respiretory err	rest,	Intervel Between	
	Physician /Medical Examiner	_	Immediate Ceuse (Final disease or condition resulting In deeth)	CAR	-	MA or as a conseq		LUNG			7.1	
	icate be executed physician end s the buriel-transit	Examiner	Sequentially list conditions, if any leading to immediate	b	Due to (d	or as a conseq	uence of):					
68760,	te be e. ysiclan	edical E	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	Due to (o	r as a consequ	uence of):					
Box 68	E 0 6	-	resulting in death) Last	d								
	a death he ette led for	Physician/N	Part il. Other significant conditions con	ntributing to death t	out not res	ulting in the ur	nderlying cause g	iven In Part 1.	23b. Did to	obacco uae contrib	oute to the cause of death?	
s, P.O	requiras that tha death cer een signed by the ettendin hould be detached for use	by Phy							1	es 2□ No 3[	Probably 4 Unknown	
Records,	S S	Completed							24a. Wes a perfor		available prior to completion of cause	
al R	Pa ate								1 🗆 Y	es 2000	1 ☐ Yes 2 ☐ No	
Vital	Physicien: The this certificata ral director, pag	o Be	25. Was case referred to medical examiner?	lospitel:		50/0 A All A		26. Place of Deat	10			
Jo L	는 무료	n: To	27. Manner of Deeth	1 ☐ Inpati 28e. Dete of Inj (Month, De	Jry	28b. Time of Injury	t 3□ DOA □	4 LI Nursing Fic		ow Injury occurred	Specify)	
Division	To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completaly filled in by the funeral	Certification:	t Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be  4 Homicide determined		jury - At ho	ome, farm, stre		Yes 2□No	r Rural Route Number,			
ā	spital or rours aft neral Dii						occurred at the t	ime, date and place.	City or Tow		or as stated.	
	he Ho in 24 h he Fui pletah	edical	(Check only 2 Madical Exami	end manner st	f examina	tion and/or Inv	estigation, In my	opinion, death occur	red at the time, d	late and place, and	due to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	4.		1000		se number	2	29d. Date signed (M March 1		
	7		30. Name and address of person who co	0-	w /			5406		I ALCII	_ ,	
	me		Dr. William Lam					erland, M	21502			
	Sta	te	31. Date find R. P. 1999	2. Regist	ag signa	iture	brown.	,				



Texs

State Registrar

Sunil K. Gupta, M.D. 625 Kent Avenue, Cumberland, MD 21502

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

12:12 PM

10d. Inside City Limits

Approximete Intervel Between Onset and Death

3 months

1 ☐ Yes 2 ☐ No

1 Ves 2 □ No

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 0253 on de 1 exander MAR 4e. Eacility Nama (If not Institution, give street and number, 4b. City, Town, or Location of Death 4c. County of De ANNApolis rurdel GEN. If Undar 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, JUNE 7 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign M 2□ F Months Days MARYLAND 219-64-9688 1956 Usual Rasidance of Dacedant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits ARUNDEL MARYLAND ANNE ANNAPOLIS 1 Yes 2 No 10e. Streat end Number 10f. Zip Coda 10g. Citizan of What Country? 1798 B. BELLE DRIVE 21401 US 12. Was Dacedent Evar in U,S.
Argued Forcas?
1 BYas 2 □ No
1f Yas, Giva
Yaar or Datas: 1982-85 13. Was Decedant of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Rece - Amarican Indien, Black, White, atc. 1 Navar Marriad 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 15. Dacedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work done duning most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) ANNAPOLIS LIGHTING 12th 0 WAREHOUSE WORKER COMPANY 17. Father's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Malden Sumema) CALVIN ALEXANDER VIRGINIA JONES 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 1798 B. BELLE DR. ANNAPOLIS, MD. 21401 ANGELA ALEXANDER (WIFE) 20b. Place of Disposition (Name of camatary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 to Burial 2 ☐ Cramation 3 ☐ Ramoval from State HILL CREST CEMETERY 3/8/99 ANNAPOLIS, MD. 4 Donation 5 DOther (Specify) 21. Signatura of Funaral Sarvica Licensaa 22. Nama and Addrass of Facility arry 2000 WM. REESE & SONS MORTUARY, P.A. 23a. Part1. Entar tha disaasa, or complications that causad the death. Do not after the mode or sying, such as cardiac or espiratory triess, shock, or heart failura. List only one ceusa on each lina. MD. 214Q1 Intervel Batween Onsat and Deeth Immediete Causa (Final diseasa or condition resulting in death) teriosclerotic Sequantlelly list conditions, if any, laeding to immadiate causa. Entar Undarlying Ceusa (Disaasa or Injury that Initiated evants rasulting in daath) Last Due to (or es a consaguance of) Dua to (or es e consequance of): 23b. Did tobacco usa contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Onknown 24e. Wes an autopsy performad? 24b. Were eutopsy findings avellabla prior to complation of cause of daath? 1 ☐ Yes 2 ☐ No 28. Place of Deeth (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 8 Other (Specify)

**Physician** /Medical **Examiner** 

pue

**Physician** 

/Medical

Examiner

Director

Funerai

Completed by

Be

**Funeral** 

Director

filed within 72 hours after death with the Maryland

21215-0020

Baltimore, Maryland

Pages 1 end 2 should be a nent of Health and Mental

Health a

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Department of Important: If any Injury or

th and Mental Hygiene.
7 is marked other than "natural", or items 23s or 28s-1 show traumatic event, the Monical Examiner must be multiped at

Examiner the burial-transit Physician/Medical ate has been signed by the attending p page 2 should be detached for use es by Completed director. Be 9 24 hours after deeth.

Funeral Director: After this letely filled in by the funeral Certification:

Hospital or Attending Physician: The lew requires that the death certificate be executed

this certificate has

Box 68760,

P.O.

Records,

of Vital

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Pert II. Other significent conditions contributing to death but not resulting in the underlying causa given in Pert I. 25. Wes casa referred to medical exeminar? 27. Mannar of Daath 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 Natural 1 Yas 2 No 2 Accident 3 Suicida 6 Could not be datamined 28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Straat end Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Cartifiai Deputy 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year)

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a and addrass of person who completed causa of death (Item 23e) (Type, Print)

tmerica Ct. 21035

within 2 To the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Year **Physician** 5, 1999 March 12:30am Vincent Louis Belmonte /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** 5129 Trailway Drive Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys 1団M 2口F 79 Yrs. **Director** 163-18-9867 30, 1920 Pennsylvania Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hem 27 le marked other than "natural", or Hema 23a or 28a-f ehow other traumatic event, the Medical Examiner must be nothed at 1 ☐ Yes 2 ₺ No Directo Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code With 20853 United States Funeral 5129 Trailway Drive death 12. Was Decedent Ever in U.S. Armed Forces? LMYes 2 D No If Yes, Give 1942— Year or Dates: 1945 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Haeith and Mental Hygiene. Important: if Item 27 ie marked other then "natural", or ite 1 Never Married 2 M Married Baltimore, Maryland 21215-0020 1 Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced White 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Fiscal Specialist Federal Government 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 10 Vincent Belmonte Maria Carmela Polichetti 19a. informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Rosina M. Belmonte (Wife) 5129 Trailway Drive, Rockville, MD 20853 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State Injury or 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 3/9/99 Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ETASTATIO COLON Examiner Due to (or es e consequence of) Examiner requires that the death certificate be executed sician and burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Box 68760 physician Physician/Medicai the Due to (or as e consequence of): 80 esn 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the e Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveileble prior to been si 24a. Was en autopsy performed? Completed completion of cause of death? certificata has 20 No Hospital or Attending Physician: director, 25. Was cese referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No After this 28e. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. tnjury et Work? Certification: 1 Netural 5 Pending 2 No hours after death. 1 Yes investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dev. Year) Signature and title of certifier 29c. License number 12 completed cause of death (Item 23e) (Type, Print) CENTER Deive ROCEVILLE

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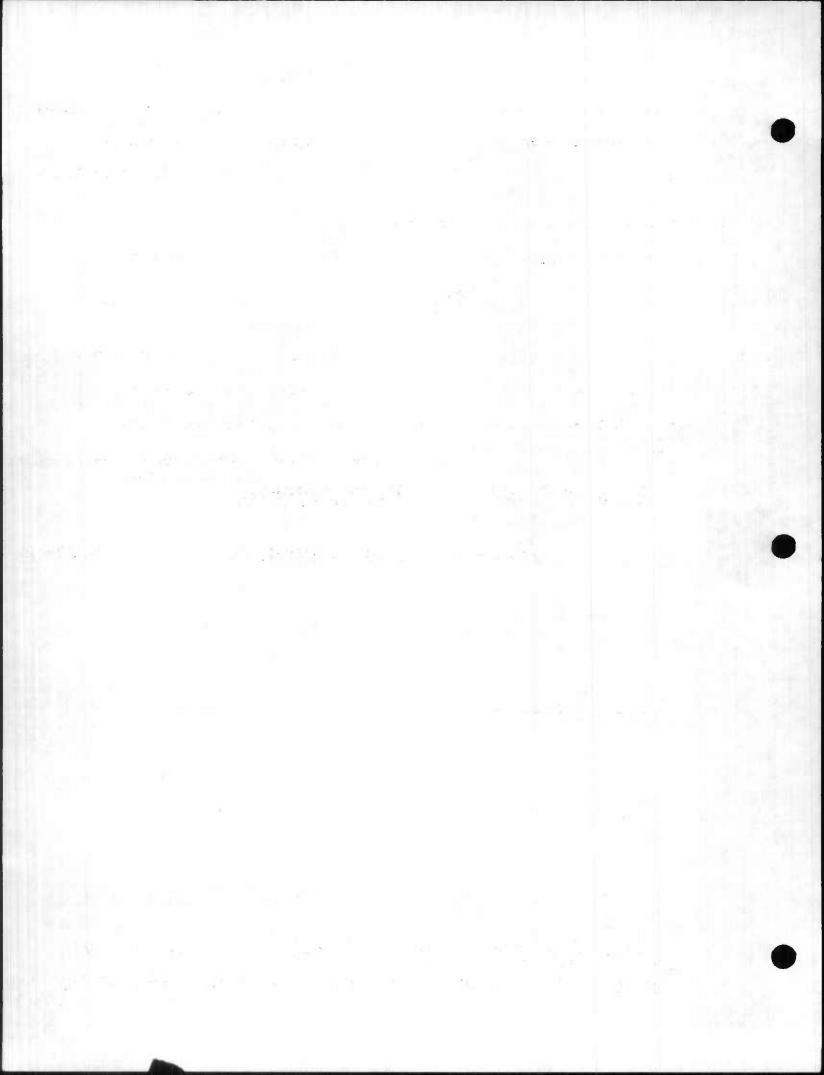
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31. Dete filed (Month, Dey, Year)

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32. Registrer's Signature

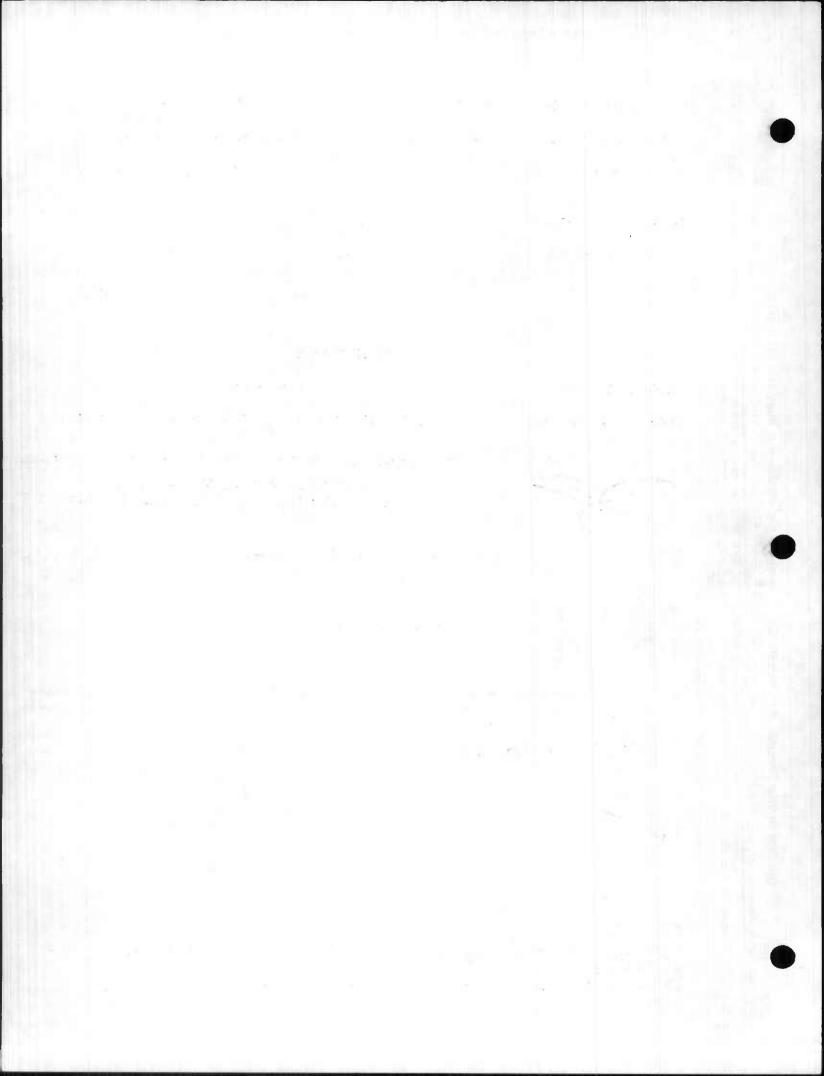


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State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Death **Physician** 03-10-1999 NATALIE L. HALLE BERENDT 2:15 PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner SILVER SPRING MARINER HEALTH CARE OF SILVER SPRING MONIGOMERY 5. Social Security Number If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) NOV - 8, 1 9. Birthplaca (Stata or Foraign 7. Aga (In vrs. last birthday) **Funeral** 1□M 2F Months Days Hours Min 84 Yrs. NEW YORK 577.16.9658 Director Usual Rasidence of Dacedani with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yas 🏂 No Directo MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 901 ARCOLA AVENUE 20902 USA permit. Pages 1 and 2 should be filed within 72 hours aftar death a Department of Haalth and Menial Hydiene. Important: If item 27 is marked other than "natural; or ferms 23a and Injury or other traumatic event, the Medical Examiner mans once. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 11. Marital Status 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 Specify: WHITE 1 ☐ Yas 2 No Specify: by 3 ₩ Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Dacedent's Education (Specify only highast grada complated) Elementery/Secondary (0-12) College (1-4or 5+) LEGAL SECRETARY LAW 18. Mothar's Nama (First, Middla, Meidan Sumama) 17. Fathar's Nama (First, Middla, Last) SOLOMON WARSHAW ROSE THAL 19b. Mailing Address (Streat end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Typa, Print) 18020 OVERWOOD DRIVE, OLNEY, MARYLAND 20832 ROSE LIPOV/DAUGHTER 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) KING DAVID MEMORIAL GDNS 3.14.99 FALLS CHURCH, VIRGINIA 21. Signature of Funaral Sarvice Deansas 22. Nama end Addrass of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or head; failure, List only one cause on each line. Approximate Interval Batwaan Onsat and Death **Physician** /Medicai Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner bunel-tren Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that Initiated avants rasulting in death) Last pue Dua to (or as a consequence of): certificata be exec Division of Vital Records, P.O. Box 68760, physician ense Physician/Medicai the Dua to (or as a consequence of): as 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco uss contribute to the csuss of death? detached signed by t 1 Yes 2 Ino 3 Probably 4 Unknown 2 24b. Wara autopsy findings available prior to complation of causa of daath? Completed 24a. Was an autopsy peen has page 2 1 Vas 2 100 1 Yes 2 ANO certificate or Attending Physician: funeral director. 25. Was cesa refarred to medical axaminar? Be 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Lo 1 Yas 2 JH 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this is 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? Certification: Aftar 5 Panding efter death. 1 Yas 2 No invastigation 2 Accidant 6 Could not be determined 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 3 ☐ Sulcida Location (Streat and Number or Rural Routa Number, City or Town, Steta) 4 | Homicida 24 hours Hospitai 29a. Certifian 🗺 Csrtifying Physician: To the best of my knowledge, deeth occurred at tha time, dete and place, and dua to the ceuse(s) end menner es stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. To the To the To the F 200. Signature and 29c. Licansa number 29d. Data signed (Month, Dey, Year) rily Nama end addrass of person who complated ceusa of deeth (Item 23e) (Type, Print) Road ton, mo 20902 eld 31. Data filed (Month, Day, Yaar) 32. Registrer's Signatura

State Registrar

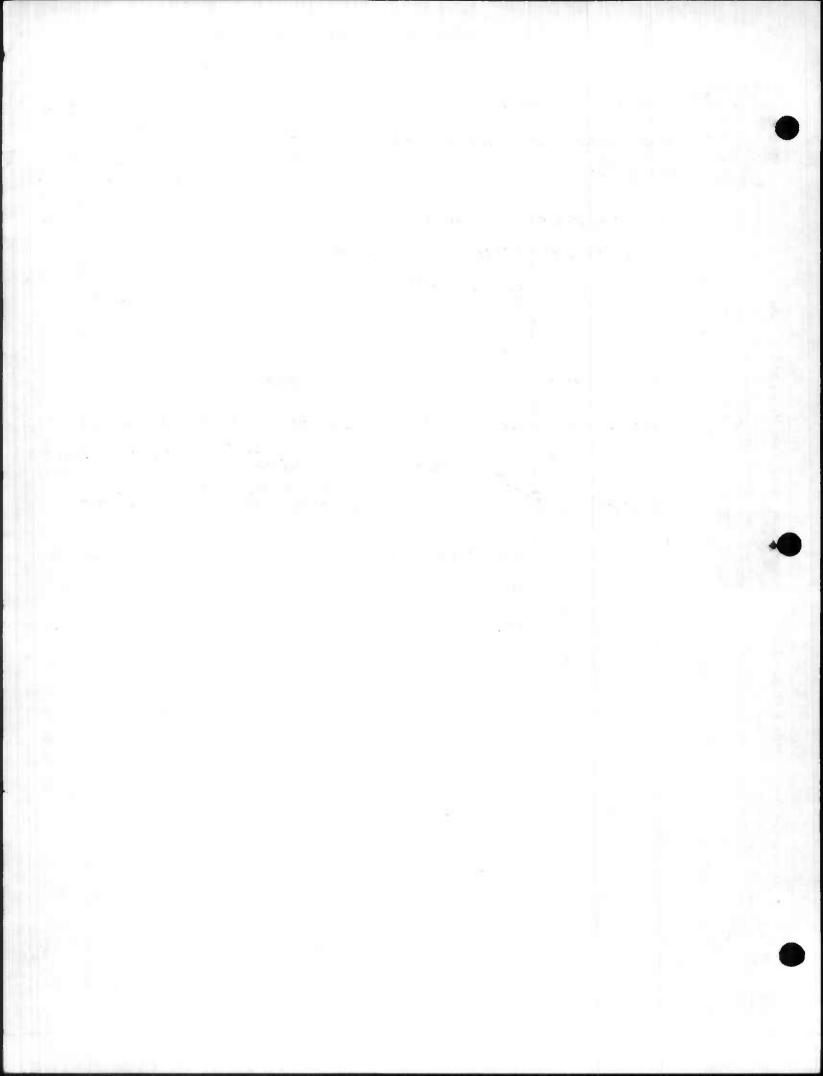
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State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** JEROME EDGAR BERNSTEIN 03.10.1999 1:31 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Rockville Shady Grove Adventist Hospital Montgomery If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 8. Dete of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** Months Deys Hours 1 □ M 2 □ F 578.40.8377 66 Director WASHINGTON, DC 03.17.1932 Usuel Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2 No MARYLAND MONTGOMERY Director **POTOMAC** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 20854 USA 9117 POTOMAC STATION LANE Peges 1 and 2 should be filed within 72 hours efter death a ment of Health end Mentel Hygiene.
mit: if item 27 is marked outher than "natural", or items 23, ury or other traumatic event, in "sedial Evarrae musury or other traumatic event, in "sedial Evarrae musury. Funeral 12. Was Decedent Ever In U,S.
Amed Forces?
1.6 Yes 2 \( \text{\text{NS}} \) \( \text{V6} - \text{\text{\text{V6}}} \) \( \text{V6} - \text{\text{V6}} \) \( \text{V6} - \text{\text{V6}} \) \( \text{V6} - \text{\text{V6}} \) \( \text{V6} - \text{V6} - \text{V6} \) \( \text{V6} - \text{V6} \) \( \text{V6} - \tex 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, 11. Marital Status Bleck. White, etc. 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementery/Secondery (0-12) College (1-4or 5+) DENTIST DENTAL 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be JOSEPH BERNSTEIN BERTHA SOCKS 2 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9117 POTOMAC STATION LANE, POTOMAC, MARYLAND 20854 ROBERTA BERNSTEIN/WIFE 20b. Plece of Disposition (Name of cametery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 3.12.99 important: If it any injury or c Department or 1 ☐ Burial 2 ☐ Cremation 3 🗷 Removel from State FALLS CHURCH, VIRGINIA 4 ☐ Donetion 5 ☐ Other (Specify) KING DAVID MEMORIAL GARDENS 21. Signature of Funerel Service Licens 22. Name end Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Finat disease or condition resulting in death) MINUTES ACUTE BRADYOCARDIA Examiner Due to (or es e consequence of) Examiner MONTHS CARDIOMYOPATHY The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Last Due to (or es e consequence of): Box 68760. MONTHS physician APLASTIC ANFMIA Physician/Medicai the Due to (or es a consequence of): 98 esn P.0. Pert II. Other algnificant conditions contributing to death but not resulting In the underlying ceuse given in Pert I. be deteched 23b. Dld tobacco use contributa to the cause of death? 1 ☐ Yas 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed pege 2 hes certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, Be 25. Wes cese referred to medicet exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2X ER/Outpetient 3□ DOA After this 27. Menner of Deeth 28a. Date of Injury (Month, Dev Year) 28b Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending 1 SeNeture 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours efter deel Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner as steted. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. within 2 To the 29d. Date signed (Month, Dey, Year) 2 Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 990/medical centeror. Rockville, md. 2080 downh Sherri

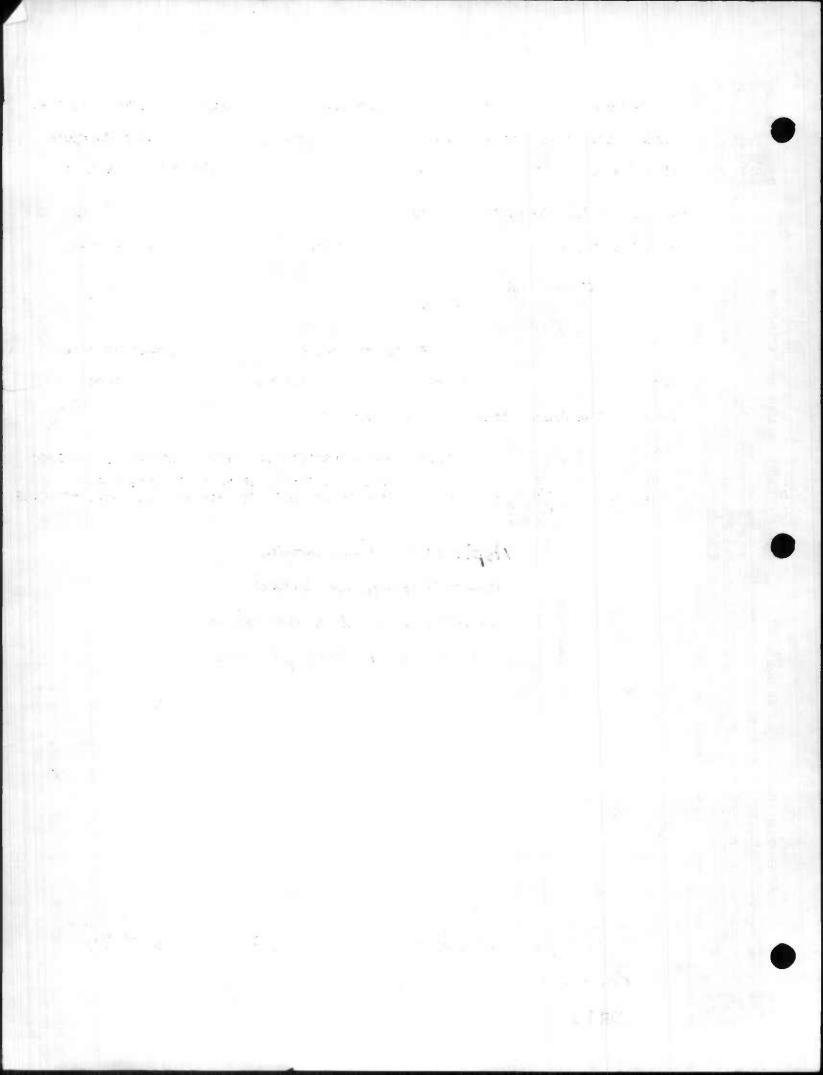
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Balt	Departition of the series of t	Fort Lincoln Cemetery 3/11/1999 Brentwood, Mary  21. Signature of Funeral Service Licensele  22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland														1 20705			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Physician 5, 1999 7:45 PM Diane E. Bergin March /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** College Prince George's 8802 34th Avenue Park If Undar 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) If Under 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 1 M 2 TF Yrs. 55 **Director** 22, 1943 Washington, D.C. 220-40-2870 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☒ No Director Maryland Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Barras 23a or must be Funeral 8802 34th Avenue 20740 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yea or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus 1 ☐ Yes 2 ☒ No If Yes, Give Year or Datas: 1 ☐ Never Merried 2 X Married natural, or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: à 3 Widowed 4 Divorced White Completed 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry 22 be filed within Hygiene. Other than Elementary/Secondery (0-12) Collega (1-4or 5+) Bookkeeper Holy Redeemer Church permit. Pages 1 and 2 should be fis Department of Health and Mental Hy Important: If Item 27 is marked oth-sary Injury or other traumatic events 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 2 Elizabeth Mills George John Adamson 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 8802 34th Avenue College Park, Maryland 20740 Thomas J. Bergin (husband) 20e. Method of Disposition Pleca of Disposition (Neme of camatery, cremetory or other plece) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Other (Specify) 03/8/99 Brentwood, Maryland Fort Lincoln Cemetery 21. Signeture of Funarel Service Licenses 22. Nema end Address of Fecility Francis J. Collins Funeral Home, Inc. amo 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Ell er the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician /Medical Immediate Cause (Finel 2 1/2 yearsdisease or condition resulting in death) , Metastatic Ovarian Cancer Examiner Due to (or es e consequance of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or es a consequence of) 88 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ Records, 24b. Were autopsy findings aveilable prior to Completed 24a. Was an autopsy performed? completion of cause of death? certificate has t irector, page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician; after death, Director: After this certifica Be 25. Was case referred to medical 26. Piaca of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Deta of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNeturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 4 Homicide filled in 24 hours a Hospitai 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

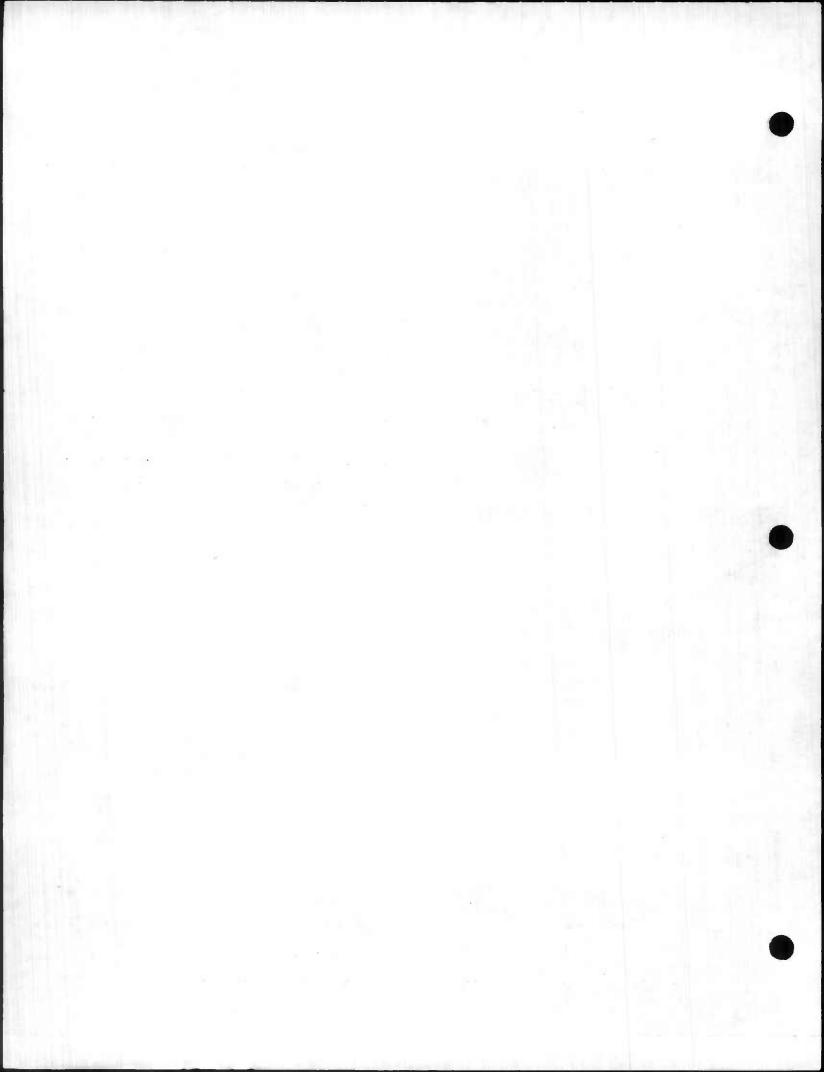
| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier within 2 To the \$ 29b. Signatura and titla of certific 29c. License number 29d. Date signed (Month, Day, Year) 2 March 8, 1999 MD 000021845 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Jane Ingham, M.B. BSFRAP 3800 Reservoir Road Washington, D.C. 31. Dete filed (Morfth, Day, Year) 32. Registrer's Signeture State

DHMH 16 Rav 6/95

Registrar

MAR 09

1999



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #10f, 3/16/99, BMW, Montg. Co. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** James Mark Broullire 1999 March 5, 7:33Am /Medical 4e Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3043 Brownstone Court Burtonsville Montgomery 8. Date of Birth (Month, Day, Year)
April 3, 1955 Washington, DC If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Days Hours 1 M 2 □ F Months 213-56-5078 43 Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 ☐ Yas 2 ☑ No Director Montgomery 28s-f Burtonsville 10e Street and Number 10f Zin Code 10g, Citizen of What Country? ò 3043 Brownstone Court -20906 -20866 Norra 23a USA Funeral Was Decedant of Hispanic Origin? (Specify Yaa or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Waa Decedent Ever In U,S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 XNo If Yes, Give 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 b 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Datas: 'natural' Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Hygiene. Automobile Elementary/Secondery (0-12) College (1-4or 5+) General Manager Dealership 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumama) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Important. If Nam 27 is marked other any Indury or other traumatic event Be John Merlin Broullire Mary T. Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Nanette M. Broullire/wife 3043 Brownstone Ct., Burtonsville, Md 20866 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval irom State Gate of Heaven Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 3/8/99 Silver Spring, MD 22. Name and Address of FacilityFrancis J. Collins Funeral 21. Signature of Funaral Service Licen Home, Inc. 500 University Blvd., West Silver Spring, MD 20901 23a. Part 1. Enter the disaase, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Due to (or as a consequence ot) Examiner iclan and burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting In death) Last Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medicai Dua to (or as a consequence of): 98 USB I P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yea 2 No 3 Probably 4 Unknown Records, þ 58 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 PNo certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medicat 26. Place of Death (Check only one) 1 Yes 20 No Other: 4 Nursing Homa 5 Pesidence 6 Other (Specify) edicai Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient After this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel 5 Panding investigation 24 hours after death.

Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 one) To the 29b. Signature and title of certifier 29c. License number

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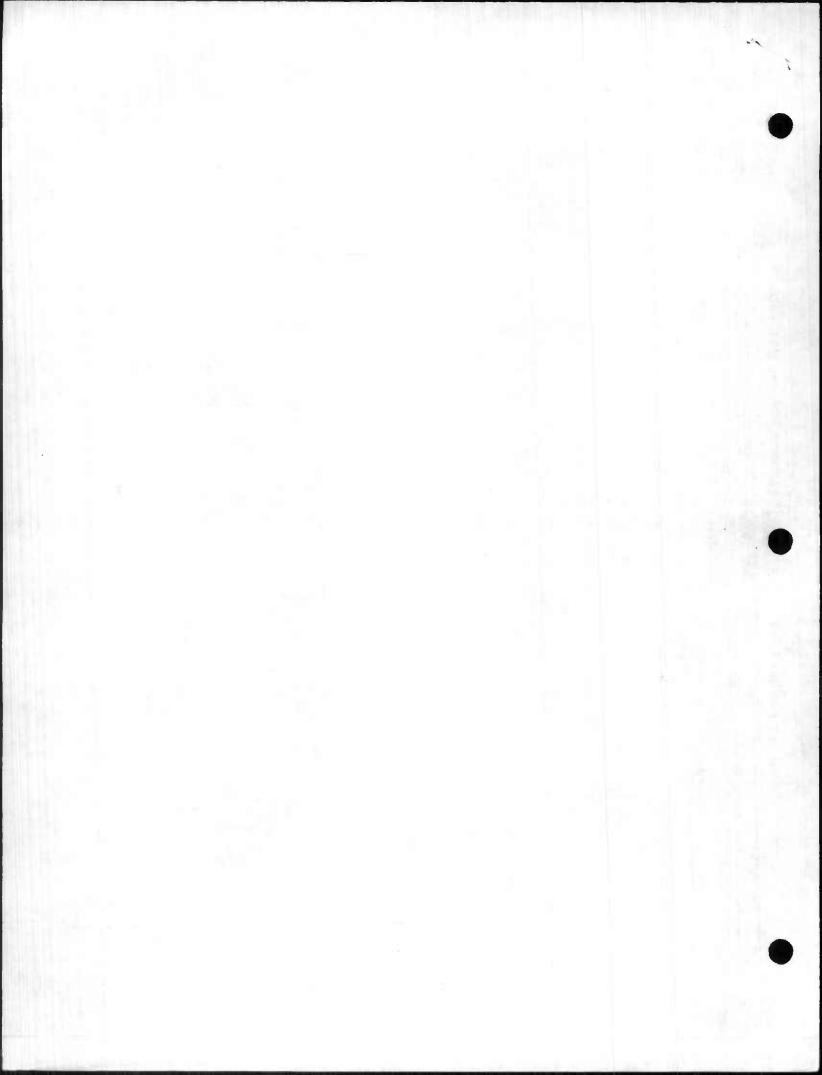
State Registrar Kajeev Ba MAR 0 9 1999 M.D. 10801

29d. Date signed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Item 23e) (Type, Print) Batra

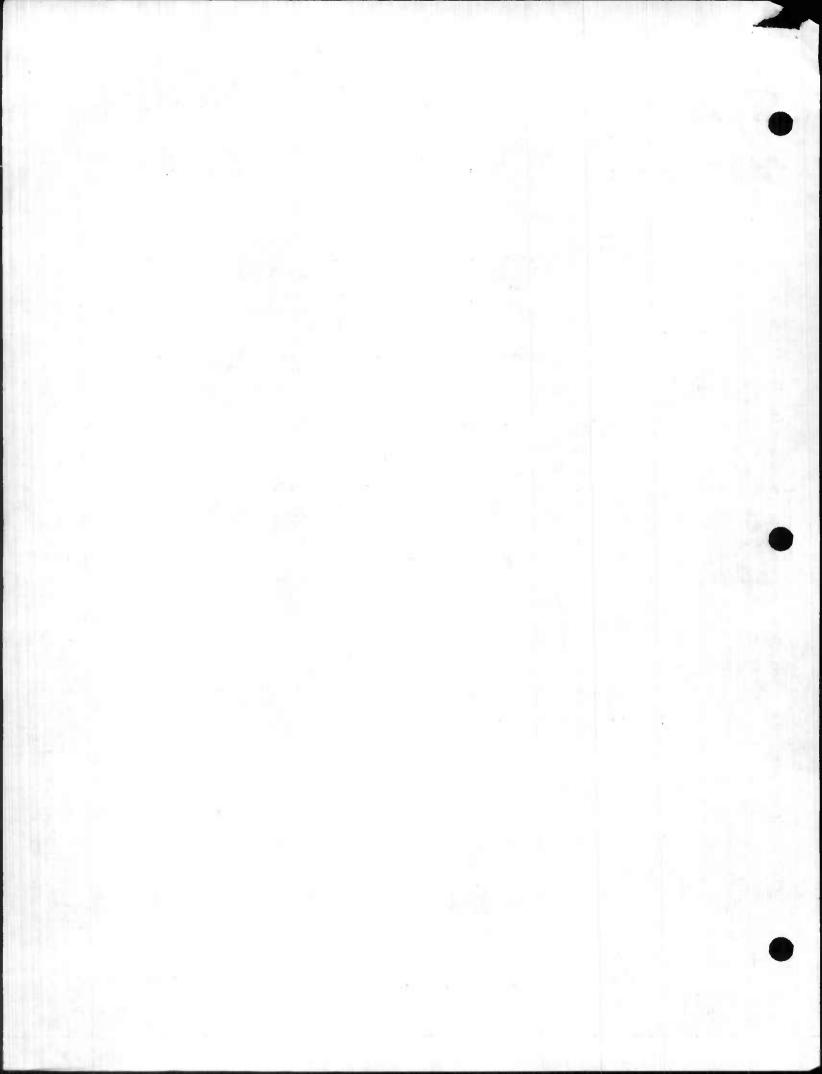
Lockwood Dr. Silver Spring, Md20901

32. Pegistrer's Signeture



DHMH 16 Rev 6/95

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Please Type or Print in Black indelible lnk. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Lucille 1999 Kirkley Bichy March 1:40a.m. 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Death William Hill Manor Talbot Easton 8. Dete of Birth (Month, Dey, Yeer)
Jan. 7, 1913 5. Social Security Number If Under 1 Year 9. Birthplece (State or Foreign 7. Age (In yrs. lest birthday) 1 M 2 TO Deys Hours Min 213-01-2106 86 Yrs Maryland Usual Residence of Decedent 10a State 10b. Counts 10c. City, Town or Location 10d Inside City Limits 1 XYes 2 No Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 14. Race - American Indien, Bleck, White, etc. 501 Dutchmans Lane 21601 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 ☐ Never Married 2 ☐ Married White 1 Yes 2 XNo Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker 0 Own Home 17. Fether's Name (First, Middle, Last) John Kirkley Margaret Hartge 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Charles E. Bichy III/Son 6513 Koziara Drive, Burke, VA 22015 20b. Plece of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, Stete Chesaveake Cremation 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from State 3/8/99 Chester 4 ☐ Donetion 5 ☐ Other (Specify) Center, LLC 22. Name and Address of Fecility Fellows, Helfenbein, & Newnam 21. Signatura of Funeral Service tipens Funeral Home, 200 S. Harrison St., Easton, Md 23a. Pentl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Intervel Between Onset end Deeth Cachesta Immediate Ceuse (Final disease or condition resulting In death) occult melignany Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Pert ft. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evellable prior to completion of ceuse of deeth? 24e. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth

Physician /Medical Examiner

permit. Paga Department of Important: If any injury or

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

7 is marked other than "natural", or items 23s or traumatic event, the Medical Examines must be a

Pagas 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiena.
ant: If Item 27 Ie marked other then "natural", or Itema 23 ary or other traumatic event, the Madical Expansion mass.

altimore, Maryland 21215-0020

with the Maryland r 28a-f show

> Examiner physician and s the burial-trans 88 esn signed by t d be detach has

requires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760

Physician/Medical à Completed page 2 2 funeral Certification:

certificate

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Aftert

after death.

24 hours a Hospital

To the Hosp within 24 ho To the Fune completely f

or Attending Physician:

25. Wes case referred to predical exeminer? 1 Yes 2 No

2 ☐ Accident

3 ☐ Sulcide

29a. Certifier (Check only one)

5 Pending investigation 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28e. Dete of Injury (Month, Day Year)

28b Time of

28c. Injury et Work? 1 Yes 2 No 28d. Describe how Injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

MI

29c. License number 125750 29d. Dete signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name end eddress of person who completed cause of deeth (ttem 23a) (Type, Print)

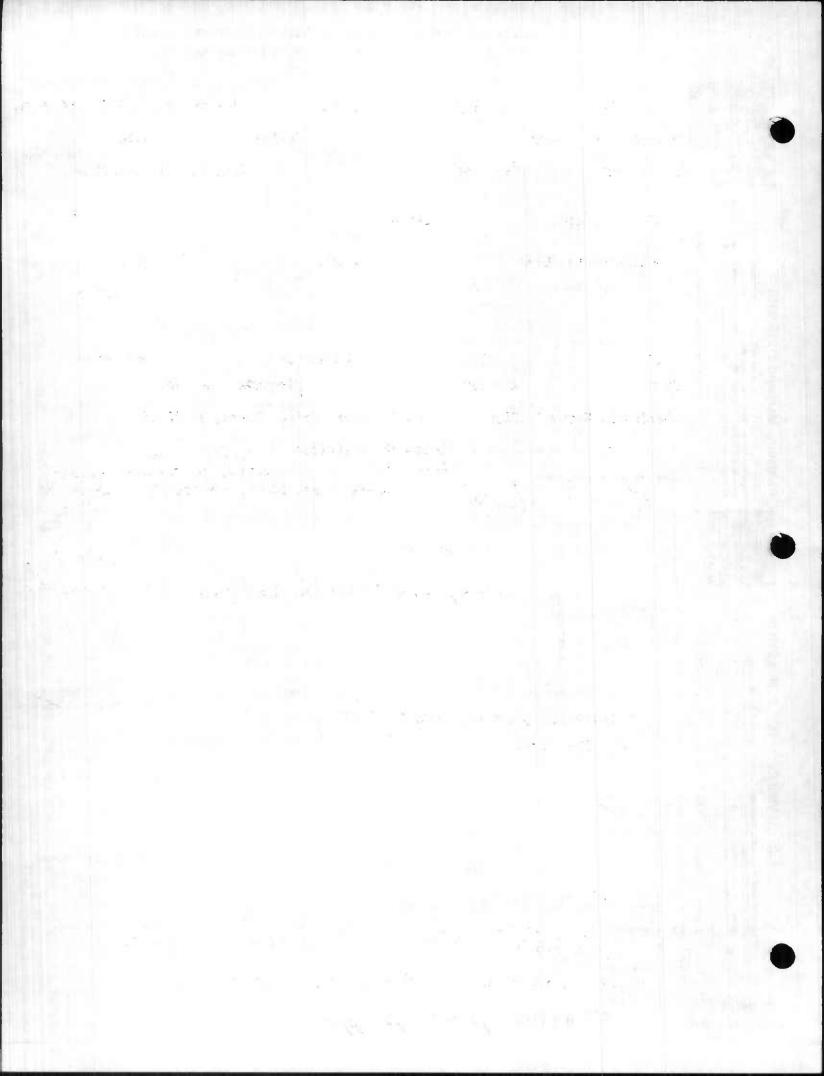
ROBERT B. SANCHEZ, M.D., 508 IDLEWILD AVENUE, EASTON, MD 21601

State Registrar

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31. Dete filed (Month, Day, Year) MAR 0 9 1999

32. Registrer's Signeture

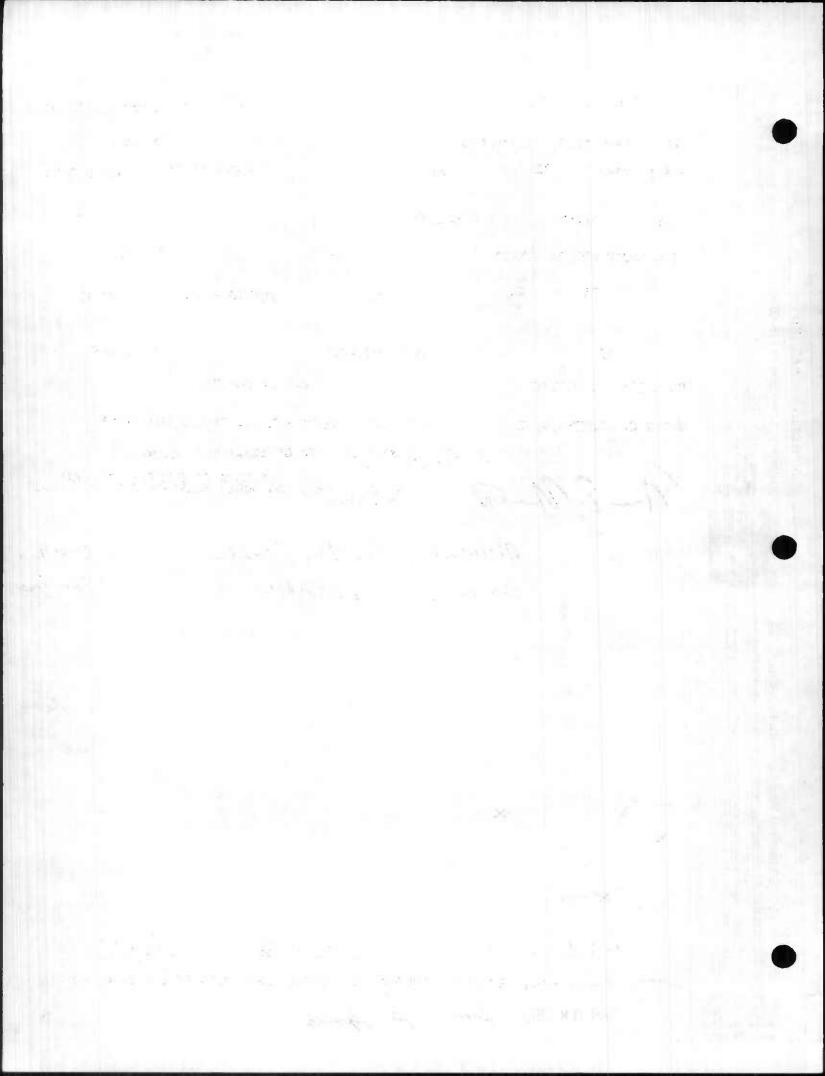


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Funeral		5. Sociel Security N	Number 6. S	өх	7. Age (In yrs.	last birthday)	If Under 1 'Months D			8. Date of Birt Month, Day MARCH 2.			lace (State or Foreign try)	i
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a how	_	10a. State	10b. County			ty, Town or Loc	ation					10	0d. Inside City Limits  1 Yes 2 □ No	
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Den	P	10e. Street and Nur					10f. Zip Co				10g. Citizen of V		try/	
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al', or iteme 23a or 28a-f show Examiner must be notified at	by Funeral	11. Maritai Status  1 ☐ Never Marr  3 ☐ Widowed	ried 3(Married	Armed For	2 □ No e		Yes, specify			ecify Yes or No- Rican, etc.) RTO RIC	RICAN Specify: WHITE			
natural',	Pa		15. Decedent's Ed	lucation		16a. Deced	ent's Usuel C	Occupation			16b. Kind of Bu	usiness/Inc	dustry	i
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T T		19a. informant's N	lame/Relationship (	Type, Print)		19b. Mailin	g Address (S	Street and Num	ber or Run	al Route Numbe	er, City or Town,	State, Zip	Code)	
er tra		NANCY C.	BENITEZ/	WIFE					STREE'		ON, MD	21601		
dg .		20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory, or other, place)										City or To	wn, Stete	
ury o			5 Other (Specif		CHE	ENTER,	LLC.	ATTON	3	/6/99	CHEST	ER		
Important: If itam 27 any injury or other trends.		21 Signature of Fu	uneral Service Lice	Jan 51	d	FU!	Name and A NERAL D, 216	HOME,	200 S	LOWS, HE	LFENBEII RRISON	N & STREE	NEWNAM T, EASTON	
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peq t	ysic	Part II. Other signif	ficant conditions c	ontributing to de	ath but not res	sulting In the un	derlying cau	se given in Pa	rt I.	23b. Dld	tobacco use co	ntribute to	the ceuse of death?	
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97 0	o l	1 Netural 2 Accident	5 Pending Investigation		h, Day Year)	Injury	м	Work?	□No					
e funere	#	3 Suicide	6 Could not be determined	288. Place	of Injury - At h	ome, farm, stre	eet, factory, o	office				ber or Rura	al Route Number,	
Director: After this d in by the funerel	ertificati	29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
Funeral Director: After	dical Certification:			niner: On the ba			estigetion, in	my opinion, d	leeth occur	red at the time,	date and placa,	and due to	the cause(s)	
o the Funeral Director: After the ompletaty filled in by the funere	Medical Certification	29e. Certifier (Check only	2 Medicat Exam	niner: On the ba	sis of examina			my opinion, d		red at the time,	date and placa,			
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24 hours efter deeth. Funeral Director: After etaly filled in by the funer	edicai	29e. Certifier (Check only one) 29b. Signeture and	2 Medicat Exam	niner: On the ba	sis of examina ner stated.	ation and/or Inv	29c. L		er e	red at the time,				

State Registrar

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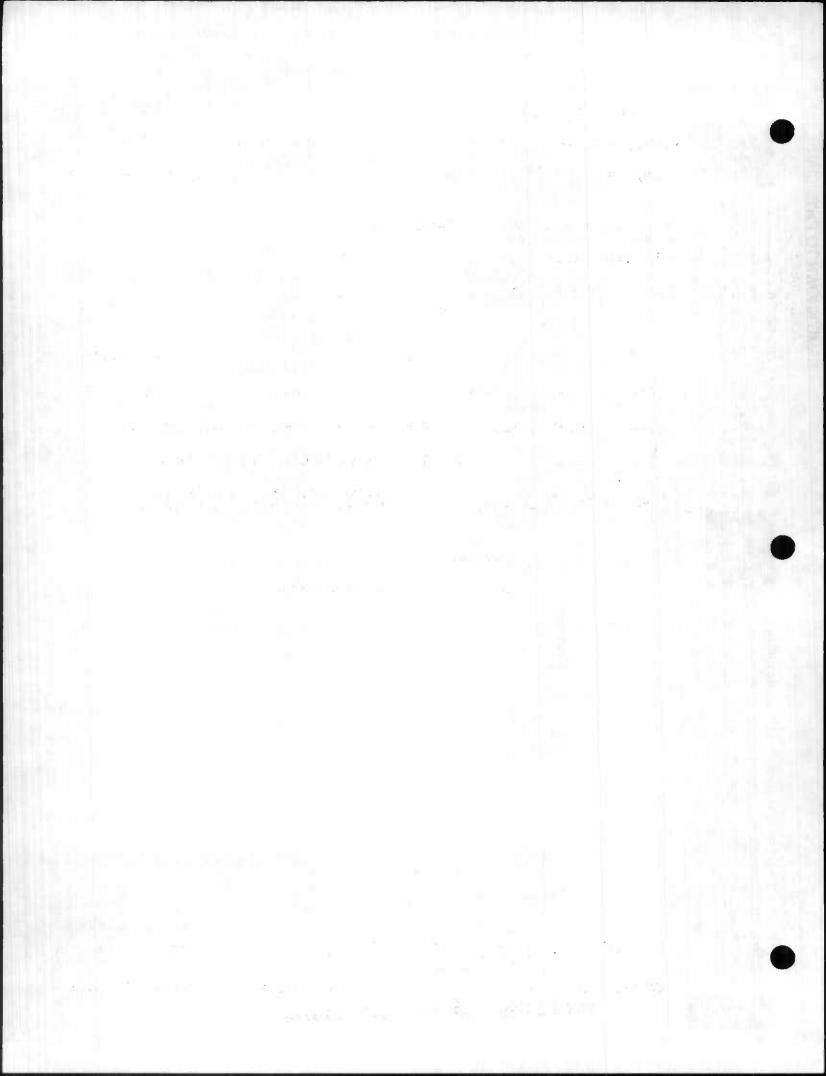


Division of Vital Records, P.O. Box 68760,

### Please Type or Print In Black Indelible Ink. Assure Ali Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

in	1. Decedent's Name (First, Middla, Last	0		Certificate of		2. Date of D		W	3. Time of Death			
	Tamas I	Dond				March	9 <sup>D⊕y</sup> 199	9 Year	9:55 PM			
al -	James L.  4a Facility Name (If not Institution, giva	Streat and number)			4b. City, Town, or I							
31	VA Maryland Health		em em		Perry Poi	nt.		ecil				
	5. Social Security Number 8. Se		n yrs. lest birth	day) If Under 1 Yes		8. Date of B	irth	9. Birthola	ce (Stata or Foraign			
		M 20 F	6 Y	Months Day	s Hours Min.	June 16						
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	Maryland Queen A	nnes	Queens						•			
2000	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Countr	γl			
	137 Scott Town			21658			USA					
	11. Maritel Status  1 Never Merried 2 Married	12. Was Decedent Eve Armed Forces? 1 X Yes 2 ☐ No If Yes, Give		13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ N		pecify Yes or N o Rican, etc.)	o- 14. Ha: Bla Specil	ce - America ick, White, ei	tc.			
-	3 ☐ Widowed 4 🍎 Divorced	Yeer or Detes: 19					100 100 100	Bla				
-	15. Decedent's Edu (Specify only highast grad Elementary/Secondary (0-12)	cation da completed) College (1-4or 5+)		Decedent's Usual Occ Give kind of work dor lifa. DO NOT usa reti	upation a during most of wor red)	king	16b. Kind of B					
-	17. Father's Name (First, Middla, Last)		W	elder	18 Mother's Nar	ne (First Middl	a, Maidan Sumai	Construction				
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ŀ	851 - City or Tow	m State										
	1 ABurial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	Maryla	aryland									
	23a. Part / Enter the disease, or comp shock, or heart failure. List only o	dications that caused the cause on each line.	e death. Do no	P.O. Box	Smith Fune 1687, Eas ying, such es cardiad	ton Mar	vland 2		Approximete Interval Between Onset and Deeth			
Immediate Cause (Final disease or condition e. Pneumonia e.												
Due to (or es a consequence of):												
Prostate Cancer with metastases												
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	that initiated events resulting in death) Last	d	e to (or as a co	nsequence of):								
-						122 Flid tobacco use postalbute to the equation						
	Part II. Other significant conditions co	ntributing to death but n	ot resulting in	the underlying cause	given in Part I.	23b. Did tobacco use contribute to the cause						
						1[	Yee 2□ No	3∐ Prob	ably 4X Unknow			
							s en autopsy formed?	ava	re autopsy findings ilable prior to apletion of cause eath?			
1						10	Yes 25No	10	Yes 2□ No			
	1 □ Yes 2 □ No											
	25. Wes case referred to medical				26. Place of De			har (Specify	)			
	examiner?	Hospital:	2 ☐ ER/Outs	patient 3 DOA	28a. Date of Injury (Month, Dey Year)  28b. Time of Injury et Work?							
	examiner?  1 Yes 2 No  27. Menner of Deeth  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Y	28b. Ti	me of 28c. In	4 LI Nursing F	-	e how injury occu	iii eu				
	examiner?  1 Yes 2 No  27. Menner of Deeth  1 Notural 5 Pending	28a. Date of Injury (Month, Dey Y.	ear) 28b. Ti	me of 28c. In	iury et fork?	28d. Describe	how injury occu (Streat and Num own, State)		Routa Number,			
cermication: 10 be	examiner?  1 Yes 2 No  27. Menner of Deeth 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Phy	28a. Date of Injury (Month, Dey Y.	- At home, farr Spacify)  ny knowledge, aminetion and	me of lury M 28c. In lury M 1 m, street, factory, office death occurred at the	iury et fork?  Yes 2 No	28f. Location City or T	(Streat and Numown, State)	ber or Rurel	eted.			
	examiner?  1 Yes 2 No  27. Menner of Deeth 1 Whatural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier (Check only 2 Medical Examination of the could be determined)	28a. Date of Injury (Month, Dey Y.  28e. Place of Injury building, etc. (.)	- At home, farr Spacify)  ny knowledge, aminetion and	me of uny M 28c. Imme of W 1 1 28c. Immediately M 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	iury et fork?  Yes 2 No	28f. Location City or T	(Streat and Numown, State)	nanner as ste , and due to	eted. the cause(s)			
	examiner?  1 Yes 2 No  27. Menner of Deeth 1 Whatural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  1 Yes 2 No 5 Pending investigation determined	28a. Date of Injury (Month, Dey Y.  28e. Place of Injury building, etc. (.)	- At home, farr Spacify)  ny knowledge, aminetion and	me of luny M 28c. In In In It In In It In In It In It In It In It In In It In It In In It In In It In In It In In In In	iury et lork?  Yes 2 No  time, date and place y opinion, death occurrence number	28f. Location City or T	(Streat and Num own, State) e cause(s) end m a, date and place	nanner as ste , and due to	eted. the cause(s)			
Medical Certification: To Be	examiner?  1 Yes 2 No  27. Menner of Deeth 1 Watural 5 Pending investigation 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  Cartifier  Cartifier  Check only 2 Medical Examination	28a. Date of Injury (Month, Dey Y.  28e. Place of Injury building, etc. (.)  relcian: To the best of miner: On the basis of exand manner states	- At home, fam Spacify)  ny knowledge, aminetion and	me of luny M 28c. In me of luny M 1  m, street, factory, office death occurred at the for investigation, in me 29c. Lice	iury et / ork?  Yes 2 No ee time, date and place y opinion, death occur	28f. Location City or T	(Streat and Num own, State) e cause(s) end m a, date and place	nanner as ste , and due to	eted. the cause(s)			
Medical Certification	examiner?  1 Yes 2 No  27. Menner of Deeth 1 Whatural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  1 Yes 2 No 5 Pending investigation determined	28a. Date of Injury (Month, Dey Y.  28e. Place of Injury building, etc. (.)  relclan: To the best of niner: On the basis of ex and manner stated	ear) 28b. Ti Inj - At home, fam Spacify)  ny knowledge, aminetion and i.	me of uny M 28c. Imme of white M 1 1 28c. Immediately M 1 1 28c. Immediately M 1 1 28c. Immediately M 1 1 28c. Lice M 1 29c. Lic	iury et lork?  Yes 2 No ee time, date and place y opinion, death occurrence number  6608	28d. Describe 28f. Location City or T s, and due to the urred at the time	(Streat and Numown, State) e cause(s) end mo, date and place 29d. Date sign	nanner as ste , and due to ed (Month, E	eted. the cause(s)			



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 3. Tima of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) Month **Physician** Ertle 03 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Atlantic General Hospital Berliu, If Undar 1 Yaar If Undar 24 Hrs. MD Worcester Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** 1**X**M 2□ F Days Hours Min. 245-07-0197 Usual Rasidenca of Decedant Yrs. 79 Director NC with the Maryland 10a. Stala 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or frame 23a or 28a-f show treumatic event, the Modical Executor must be notified at 1 Yas 2 XNO Worcester Directo MD Ocean City 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 13016 N. Shore RD USA 21842 Funeral filed within 72 hours efter death Hygiena. 12. Was Decedant Evar in U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. 11. Maritai Status Black, Whita, atc. 1 XYas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 2 No WW11 Specify: Specify: White þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elemantery/Secondary (0-12) Collega (1-4or 5+) Accountant U.S. Government permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked othe any liquy or other treumatic event place. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) **Purdie Britt** Addie Ivv 19b. Malling Addrass (Straet and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Joan Britt/ Wife 13016 N. Shore RD Ocean City, MD 21842 20b. Placa of Disposition (Name of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Seburial 2 Cramation 3 Ramoval from Stata Sunset Memorial Park 3/11/99 Berlin, MD 4 ☐ Donation 5 ☐ Othar (Spacify) 22. Nama and Addrass of Facility Burbage Funeral Home 108 William st. Berlin, MD 21811 only ona causa of aach lina. Approximete Intarval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical STAGE LUNG Carcinoma **Examiner** Dua to (or as a consequanca of): Physician/Medical Examiner Dua N (or as a consequence of): Discase the death certificate be axecuted attending physician and for use es the buriel-trensit Sequantially list conditions, if any, laading to Immadiala cause. Enter Underlying Causa (Disaasa or Injury that Initiated evants rasulting In daath) Last Dua to (or as a consequanca of): signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No Preummin Completed by 24b. Wara autopsy findings availabla prior to complation of cause of death? 24a. Was an autopsy parformad? certificata hes b lirector, page 2 s 1 ☐ Yas 2 No 25. Was casa rafarred to madical axaminar? Be 26. Placa of Daath (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA After this 28d. Dascribe how Injury occurred 27. Mannar of Death 28b Time of 28c. Injury et Work? 1 Naturel 2 Accident 5 Pending Invastigation 1 ☐ Yas 2 ☐ No Director 28a. Placa of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 6 Could not ba 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 4 Homicide • Funerei Dire Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the causa(s) and menner es steted. 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the causa(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2. To the f 29d. Data signed (Month, Day, Year) 29c. Licansa number

10

Registrar

Heal Howay 31. Data filad (Month, Day, Year) 32. Registrar's Signatura MAR 0 9 1999

ress of person who completed cause of death (Itam 23a) (Type, Print)

Bulin, mo 21811 Jeffry MATUNT, DO

H-0053714

03/06

**DHMH 16 Rev 6/95** 

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			State of Maryl		tificate of			Reg. No.	9 0	9105	
Phys	ician	1. Decedent's Neme (First, Middle, La		D DICHO	D		2. Dete of De Month	Dey	Yeer	3. Time of Deeth	
/Me	dical	GERTRUDE LE		D BISHO	P	4b. City, Town, or	Marc		999	1553	
} Exam	niner	PENINSULA REGIONA		ENTER		SAL	ISBURY	Wí	COMIC	O	
Funer Directo			Sex 7. Age (In 65	yrs. lest birthdey) Yrs.	If Under 1 Year Months Deys			Dey, Year) 9. B		ece (Stete or Foreign ry) MD	
and and		10a. Siate 10b. County	10c	. City, Town or Loc	alion				10	d. fnslde City Limits	
Many First	to	MD Worces	ster S	now Hill						1 X Yes 2 □ No	
th the	Director	10e. Street end Number			10f. Zip Code			10g. Citizen of	Whet Count	ry?	
23a			ne Lane		2186	53					
Maryland 21213-0020 d 2 should be filed within 72 hours after death with the Maryland the nd Mental hygiene. It is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Medical Exponent marks	by Funeral	3 Widowed 4 □ Divorced	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		U.S. 13. Was Decedent of Hispenic Origin? If Yes, spacify Cuben, Mexican, Put  1 ☐ Yes 2 □ No Specify:		pecify Yes or No o Rican, etc.)		ck, White, e	etc.	
5-0 72 ho	eted	15. Decedent's E (Specify only highest gro		16e. Decede	ent's Usuel Occu	pation	10d. fnslde City Lin   10d Yes 2				
within sene.	Completed	Elementery/Secondery (0-12)	College (1-4or 5+)			during most of wo	9			6.	
nd 212 e filed withi al Hygiene. other than	S	10 17. Father's Neme (First, Middle, Last	1	Owi	ner/ Op	T	no /Eirot Middle			e Store	
ire, Maryland : s 1 end 2 should be filed f Heelth end Mental Hyg item 27 is merked other other traumatic event,	Be								10)		
Aarylat 2 should b end Ments la marked summatic en	J.	19e. fnformant's Neme/Reletionship (					Stete Zip (	Code)			
1 end 2 Heelth er em 27 la other trau		Harry Bishop, J	**								
Baltimore, M pemit. Pages 1 end 2 Department of Heelin e Important: If item 27 is		20e. Method of Disposition  XD Burial 2 Cremetion 3 C 4 Donetion 5 Other (Special	Removel from State	b. Plece of Dispos cametery, crem Riverside	etory or other ple						
Demit. Departimontal	once	21. Signature of Funeral Service Lice	nsee	22.	Name end Addre		_			ne	
Physicia /Medica Examine	ai er	23e. Part f. Enter the disease, or com- shock, or meen feilure. List only Immediate Ceuse (Finel disease or condition resulting in death)	Myow		artin	ing, such es cardia	c or respiretory e	errest,	,	Approximate intervel Between Onset end Deeth	
BOX b&/bU, eeth certificete be executed ettending physician end for use es the buriel-trensit	Physician/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Lest	c	o (or es e consequ							
. 0 0 2	sicia	Part II. Other eignificent conditions of	contributing to death but not	resulting In the un-	derlying cause gi	iven in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of death?	
es that the deeth cer igned by the ettendin be deteched for use	by Phy						1 🗆	Yee 2□No	3 Prob	ably 4 Unknown	
ecoro ew requir ss been s 2 should	Completed								com	ileble prior to	
The The cate of pag							1 🗆	Yes 25 No	1 🗆	Yes 2□ No	
ysician: The l ysician: The l s certificate he director, page	Be	25. Was case referred to medical examiner?	Hospital:		_ Ot	hor:	eth (Check only				
	ation: To	1 Yes 2 No  27. Menner of Deeth 1 Neturel 5 Pending 2 Accident Investigation	28e. Date of fnjury (Month, Dey Yea	2 ER/Outpetient 28b. Time of Injury	28c. Inju	4 □ Nursing r		idenca 8 Oth how injury occur		)	
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined		At home, farm, stre	et, factory, offica			on (Street end Number or Rurel Route Number, r Town, Stete)			
To the Hospital of within 24 hours at To the Funeral D completely filled it	edical	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Example 1	yelcian: To the best of my niner: On the basis of exam end menner stated.	knowledge, death ninelion end/or Inve	occurred et the ti estigetion, in my	ime, dete end plece opinion, deeth occu	, end due to the irred et the time,	cause(s) and mo date end pleca,	enner es sta end due to	ited. the ceuse(s)	
To the Tourn	×	29b. Signeture end title of certifier			29c. Licen			29d. Dete signe	d (Month, D	Jey, Year)	
		1 Xamel	-peg		D	90xx	9		3 - 2	-99	
	6	30. Neme and address of person who		Item 23a) (Type, P	- 4	305	Som	JOVAY	ms .	21907	
S Regis	tate strar	31. Dete filed (Month, Dey, Yeer)	32. Registrer's Si	ignature	loa	1/2/					

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	REGISTRAR		CERT	FICATE (	OF DEATH	REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH						
	Francis R. 1	Brown,	Sr.			3 - 11	- 99	4:45 P. M						
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthd	y) IF UNDER 1 Y	AR IF UNDER 24 HRS.	7. DATE OF BIRTH		RTHPLACE (State or Foreign						
	169-18-2077	1 M 2 F	80 yrs	MONTHS D	YS HOURS MIN.	(Month, Day, Year)	Co	ountry)						
	9a. FACILITY NAME (If not institution, give str	net and number)		01 OUTY TO		8-29-18		lentown, Pa.						
œ			Hill Road	Poc	whor Location of D moke Cit		COUNTY OF DEATH							
0	RESIDENCE OF DECEDENT	a bilew				-1	Worce	ster						
입	10a, STATE 10b, COUNTY		10c	CITY, TOWN OR L	OCATION			10d. INSIDE CITY						
<u>E</u>	Md. Wor	cester			ce City			LIMITS?						
5	10e. STREET AND NUMBER			O C O III O		-		1 TYES 2 K NO						
Z			-		10f. ZIP CODE		U.S.	OF WHAT COUNTRY?						
ÿ	2301 Old Snow	Hill R	oad		21851		0.5.	Α.						
FUNERAL DIRECTOR	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARMED			NIC ORIGIN? (Specify Yes	or No 14. R	ACE — American Indien, lieck, White, etc.						
ВУ	1 Never Married 2 Married 3 W Widowed 4 Divorced	IF YES, GIVE WA	YES 2 NO		i, specify Cuban, Maxica YES 2 X NO Special			pocify: white						
	3 12 widowed 4 Divorced	1941-	1945				1	wnite						
	15. DECEDENT'S EDUC. (Specify only highest grade of		16a. DECEDEN	r's USUAL OCCU	PATION g most of working	16b. KIND OF BUS								
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NO	use retired.)				wer Co.						
4	8		maint	enance	truck of	perator -								
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)							
BE	Henry H. Brow	n			Mai	ry Jaimso	n Brow	n .						
8	19a. INFORMANT'S NAME (Type/Print)		19b. MAIL	NG ADDRESS (St	eet and Number or Rural	Route Number, City or Town	n, State, Zip Code,	)						
Francis R. Brown, Jr. 6610 Crooked Oak Dr., Snow Hill, Md. 2  208. METHOD OF DISPOSITION  208. PLACE AND DATE OF DISPOSITION (Name of Date   20c. LOCATION - City of Town,														
												4 Donetion 5 Other (Specify)   Commoder   Commode		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  P.O. Box 8													
	Dennis Funeral Home, Snow Hill, M													
-	23. PART i. Enter the diseases, or complications that coused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, Approximate													
	23. PART i. Enter the diseases, or co shock, or heart feilure. L	omplications thet	coused the deeth. D	o not enter the	mode of dying, suc	h ae cardiac or reapi	ratory arrest,	Approximate						
	IMMEDIATE CAUSE (Final	int only one caus	e on each line.					Interval Between Onset and Death						
ı	disease or condition resulting in desth)	CD	r Du	Ima	mal	9		5000						
ı	DUE TO (OR AS A CONTEQUENCE OF):													
2		$C \in \mathcal{C}$	DPD					Cher						
CERTIFICATION	Sequentieily list conditions, if any, leading to immediate	DUE TO	OR AS A CONSEQUENCE	OF):				H						
X	cause. Enter UNDERLYING	70	hac	0	use			50 ms						
Ē	CAUSE (Disease or injury that initiated events	DUE TO (	OR AS A CONSEQUENCE	OF):										
E	resulting in deeth) LAST													
A	PART ii. Other aignificent conditione	contributing to	leath but not reaulting	g in the under	ying ceuse given in	Part i. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO						
EDICAL						1 TYES 2		COMPLETION OF CAUSE						
						x	X	OF DEATH?						
Σ	DID TOBACCO USE CONTR	IBUTE TO CAL	ISE OF DEATH	YES NO	UNCERTAI			1 TYES 2 THO						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			EATH (Check only										
200		HOSPITAL:		OTHER:										
¥	27. MANNER OF DEATH		ER/Outpatient 3 DO/		Home 5 X Rasidence									
	1 Netural 5 Pending	28a. DATE OF II (Month, Day		NJURY	INJURY AT WORK?	28d. DEŞCRIBE HOW II	NJURY OCCURED							
À	2 Accident Investigation				YES 2 NO									
<u>n</u>	3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE OF building, at	INJURY — At home, fari ic. (Specify)	n, streat, factory,	offica	281, LOCATION (Street a City or Town, State)	nd Number or Au	rel Route Number,						
ᆲ	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	AN: To the best of m	y knowledge, death occ	arred at the time,	data and place, and due	to the cause(a) and man	ner as stated.							
COMPLETED								e(s) and manner as stated.						
U I	290. SIGNATURE AND THE OF CENTIFIER	1	^		29c. LICENSE NUI			IED (Month, Day, Year)						
∞ ∥	( M 116	1	1		LIVI	1911	<b>&gt;</b> 5/	12/90						
유	30. RAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (ITEM 27) (7)	pe, Print)	IT 10	-/-	2/	12/1						
	Charles 5	Lant	TAO	30. Print)	5 1000	27,50	ride	104						
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR	S SIGNATURE	PI	como	They !	no e	21807						
111	The state of the s			1	,			-						
	MAR 1 2 1999	Blinson		Board	/									

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiana

_						iviaiyia		Certifica		Death		Reg. No. 9 9	0	9107	
п	Physic	ian	1. Dacedant's Name (First		1)						2. Data of De Month	Day	Yaar	3. Tima of Death	
-8	/Medi		Hilda J. Bu								March	8 1999	)	10:35p.m.	
	Exami	ner	4a. Facility Name (If not ins	stitution, giva	straat and numb	er)				4b. City, Town, or	Location of Daat	h 4c. County	of Daath		
			Egle Nursing	g Home						Lonaconi	.ng	Allega	any		
	Funeral		5. Social Security Number	6. Sa		Aga (In yrs	. last birth	day) If Und	ar 1 Yaar Deys			th Veer	9. Birth	pleca (Stata or Foreign	
ш	Director		216-22-9716	11.	JM 20 <b>X</b> F	91	Y	rs.	Deys	Hours Min	Septem	ber 15 1	1907	MD	
	D.		Usual Rasidanca of Dacad												
	how			county				or Location					1	10d. Inside City Limits	
	the Marylan 28a-f show	io	MD A	legany	y	Lo	naco	ning						1 ☐ Yes 2 ☑ No	
	th with the 23a or 28 int be not	al Direc	10e. Street and Numbar 17009 Lower	George	es Creek	Road	SW	10f. Z	ip Coda 2153	39		10g. Citizen of USA		ntry?	
020	72 hours after death with the Maryland "netural", or items 23s or 28s-f show added Examiner must be notified at	by Funeral Director	11. Maritel Status 1 □ Navar Married 2[ 3 ☑ Widowad 4 □ Di		12. Was Decede Armad Force 1 Yes 2 It Yas, Giva Year or Deta	is? ☑ No	J,S.	13. Was Dec It Yas, sp 1 ☐ Yas		Hispanic Origin? (S an, Mexican, Puar Specify:	Specify Yas or No to Rican, atc.)		ce - Amaric ck, White,	etc.	
21215-0020	.c	Completed	(Specify only Elementery/Secondery (		cation la complated) College (1-4c	or 5+)				pation during most of wo	rking	16b. Kind of 8		dustry	
22	tygie her nt, II	Telephone Operator Tel  17. Fether's Neme (First, Middle, Last)  18. Mothar's Name (First, Middle, Maidal  19. Company of the								Telepho	*				
Maryland	2 should be filed with and Mental Hygiane. Is marked other than aumatic event, the M										, Maidan Suman	na)			
yla	should be nd Mental marked o	Hugh Stafford Agnes Camero									meron				
lar	and and le m		19a. Informant's Neme/Ra							and Number or R					
	and aalth n 27 er tr	Shirley Clark daughter 2702 Meadowridge Court, Myersville,  20a. Mathod of Disposition 1 © Burial 2 © Cramation 3 © Ramoval from State 4 © Donetion 5 © Other (Specify)  20b. Pleca of Disposition (Name of cematary, cramatory or other place) 4 © Donetion 5 © Other (Specify)  21. Signature of Funeral Sarvice Licansee  22. Nama and Addrass of Facility  23. Nama and Addrass of Facility  24. Nama and Addrass of Facility  25. Nama and Addrass of Facility  26. Proof Funeral Home P										ville, N	1D 21	//3	
ore	Pagas 1 and the north of Haury or other		20a. Mathod of Disposition 1	stice 2 DE	lamous literam Cha	20b.	Pleca of Comatary,	Disposition (Na cramatory or	ame of other pla	ce)	March 1	3 <sup>20c.</sup> Location	City or To	own, Steta	
Ĕ	Pag nent int: It		4 □ Donetion 5 □ Ot			ILE		Hill (		1	1999	Moscow			
Baltimore,	permit. Pag Department Important: It any injury o		21. Signature of Funeral S	arvice Licans	99					ass of Facility				<u> </u>	
ω	Depariment important		▶ Games	E m	Kenze	i				kKenzie			Α.		
			23e. Part1. Entar tha disas shock, or haart teilura	sa, or compli List only or	ications that caus ne ceusa on aacl	sad tha dae h lina.	th. Do no	t antar the mo	da ot dyn	ng, such as cardia	c or raspiretory a	rrest,		Approximate interval Between	
Į.	Physician /Medical Examiner		Immediata Causa (Final disaasa or condition rasulting in daath)		Ce	rehi	vas	rule.	Aca	cident			1	3 wh.	
		Jer	Dua to (or as a consequence of):										İ		
o,	ficata be axecuted physician and as the burial-transit	Examiner	Sequantially list conditions if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury		0	Dua to (	or as a co	nsequance of	):						
ox 68760,	SE CO. 65	/Medical	that initieted avants rasulting in death) Last		d	Due to (or es a consequenca of):									
Вох	attar	Physician/M													
P.O.	tha d	ysi	Pert II. Other significant co						causa giv	van in Part I.	23b. Did	tobacco use co	ntribute to	o the cause of death?	
S, D	requires that the de been signed by the should be deteched	by Pt	Recent p	neun	ronia,	den	ente	9			10	Yes 2 No	3 Proi	bably 4 Unknown	
of Vital Records,	2 0 CI	Completed	Recent p		nemia,	Po	/7 m-	rulgia		-		an autopsy rmad?	av	ara autopsy findings alleble prior to mpletion of cause deeth?	
<u> </u>	Tha la ata ha paga	ő	rheumat	Lica							10	Yas 2 No	1[	□Yas 2□No	
<u> </u>	cartificata	Be (	25. Was casa refarred to m	edical						26. Place of Dec	ath (Check only o	ona)	-		
>		ToE	axaminar? 1 ☐ Yes 2 No	Н	lospital:	atient 2	ER/Outp	atient 3 D	OA Oth		lome 5□ Rasi		ar (Specif	(v)	
	Afta Afta Iuna			anding nvestigation	28a. Date of in (Month, I	njury Da <i>y Year)</i>	28b. Tin Inju	na of Iry M	28c. Injur Wor 1 🔲			how injury occur		,,	
T .	구현목으	Certification:		could not be latarmined	28a. Piaca of building,	Injury - At h atc. (Speci	oma, farm	, straet, fecto	ry, offica		28f. Location ( City or To		er or Rura	al Routa Number,	
The state of the course of the									innar as st	tated. the cause(s)					
	within 2 To the comple	M	29b. Signature and title etc.	ertifier				29	c. Licans	a number		29d. Data signe	d (Month	Dev. Year)	
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	nes		30. Name and addrass of portion of the state	Fragin who co	7	f death (Ital	m 23a) (T)	pe, Print)	, 1	ry Lon	1 40 -1	K. 1	711	-20	
		10	31. Data filed (Month, Day,	Year)		strer's Sign		-yw	110	y on	acony,	100	213	-/	
	Sta Registr	-	448D 4 1	9	Banne	8		Source St.	,						

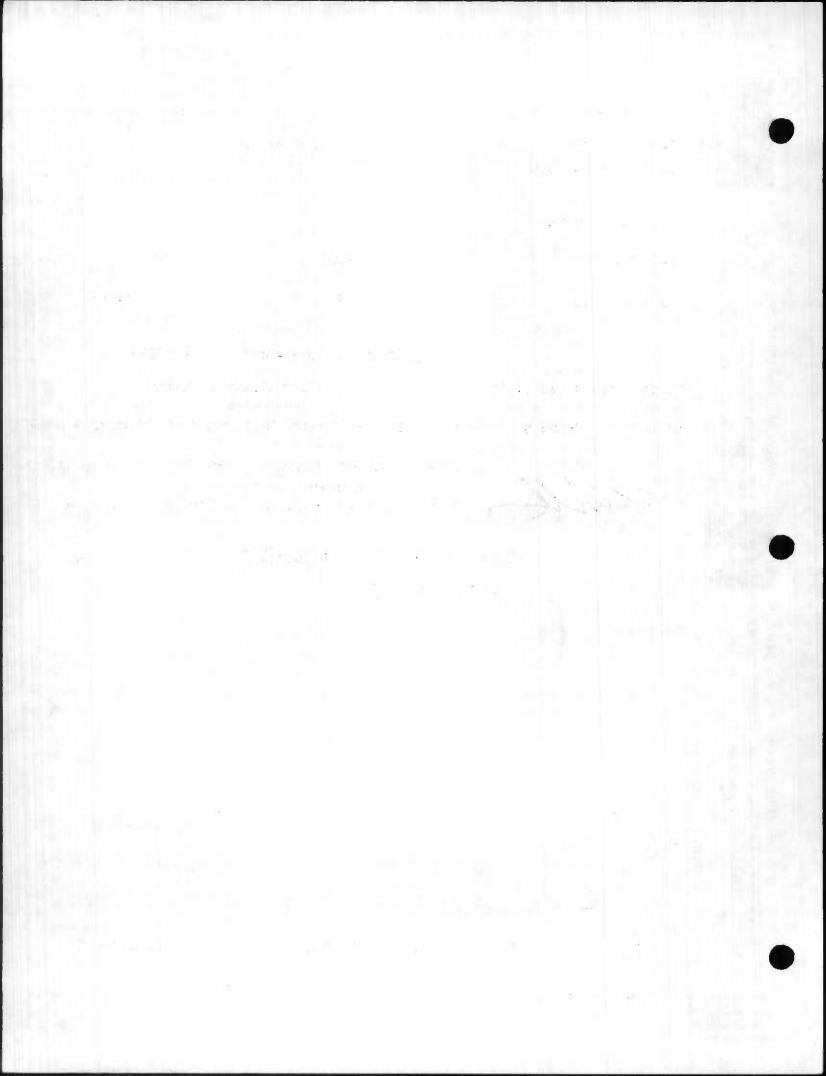
pen I HAM

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 1918

					Cer	tificat	e of	Death			Reg. No.	U 2	110		
!.:	1. Decedent's Nen	ne (First, Middle,	Last)							2. Dete of D	eeth Dey	Yeer	3. Tim	e of Deeth	
nysician Medical kaminer			Buckley, J					4b. City, To	wn, or Lo	March	10, 1	999 y of Deeth	11:0	oo a.m	
11111101	4285 St	trauss	Avenue					India	n H	ead	Cha	rles			
al or	5. Social Security 1 7 0 4 - 1 4 -	Number 6	Sex 7. Ag		last birthday) Yrs.	If Unde Months	1 Yeer		24 Hrs. Min.	8. Dete of B (Month, D		9. Birthp	viece (Ste	ginia	
	Usuel Residence	1								nugus					
	10e. Stete	10b. County			y, Town or Lo							1		le City Limits	
cto	Maryland	Charle	es	Inc	dian He	ead								Yes 2 □ No	
Directo	10e. Street end Nu	ımber				10f. Zip					10g. Citizen of	What Cour	ntry?		
	4285 Str	auss Ave					640				U.S.				
by Funeral	11. Meritel Status 1 □ Never Mer 3 ☒ Widowed	ried 2 Married	12. Wes Decedent Armed Forces?  1  Yes 2  If Yes, Give Yeer or Dates:	?		Was Dece f Yes, spe l □ Yes			gin? (Spo i, Puerto	ecify Yes or N Rican, etc.)		y:White			
eted	(Spe	15. Decadent's cify only highest	Education grede completed)		16e. Deced	edent's Usuel Occupetion re kind of work done during most of wor DO NOT use retired)			of work	ing	16b. Kind of E	of Business/Industry			
Completed	Elementery/Sec		College (1-4or	5+)							202				
Cor	12				Typese	etter	/ 5	-							
Be	17. Fether's Neme									lame (First, Middle, Meiden Sumerne)					
2	George L	ewis Buc	kley, Sr.								h Norwood				
	19a. Informent's N	leme/Reletionship	(Type, Print)		19b. Meilir	ng Addres	s (Street	tend Numbe	er or Run	el Route Num	ber, City or Towr	n, Stete, Zip	Code)		
Examiner	4 Donetion 21. Signature of F	Cremetion 3 5 Other (Special Service Little Little List or Little List or Creme	omplications that Jause on each li	M006 d the deeth	22 William 1568 42 Mills 1568	emete: Name and illian 270 Her the mode	ry nd Addre ms E awth	March ess of Fecilit Tunera norne ng, such es	l Ho Rd.,	me, P. India or respiretory	Lawrence A. n. Head, errest,	evill	e, V	7irginia	
	Sequentially list or if eny, leading to it cause. Enter Und Ceuse (Diseese or that initiated event resulting in deeth)	S	c	Due to (or	r es e conseq										
Physiclan/M	Pert II. Other signi	ficant conditions	contributing to death b	out not resu	uiting in the u	nderlying	ause gi	ven in Pert i		23b. DI	d tobacco use c	ontribute t	o the car	use of death?	
by Phy										10	Yes 2□ No	3 □ Pro	bably	Unknown	
The state of the s										24a. We per	s en eutopsy formed?	6/	rellable p	psy findings rior to of cause	
200										1 🗆	Yes 20 No	1	□Yes	2□ No	
Be	25. Wes case refe exeminer?	rred to medical					- In-		of Deat	h (Check only	one)				
9	1 □ Yes 2日	No	Hospitel: 1   Inpati		ER/Outpetien		JA		irsing Ho	-	sidenca 6 □O		fy)		
	27. Menner of Dee Neturel 2 Accident	5 Pending Investigat		ary by Year)	28b. Time of Injury	М	28c. Inju Wo 1 □	ryet ork? ]Yes 2 □	No	28d. Describe	how injury occu	irred			
Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine		jury - At ho c. (Specify	ome, farm, str	eet, fector	y, office			28f. Location City or T	(Street end Num own, Stete)	ber or Run	al Route	Number,	
edical	29a. Certifier (Check only one)		Physicien: To the best aminer: On the basis of end menner st	f examinat										use(s)	
Me	29b. Signeture end	d title of certifier				29	c. Licen:	se number			29d. Date sign	ed (Month,	Dey, Ye	ar)	
	1 Ko	ull	M - M	co On	<b>~</b>	C	77	£3	5	2	3/1	00	79		
	30. Neme end edd	ress of person wh	no completed cause of o	deeth (Item	23a) (Type,	Print)									
State	KRISHAN 31. Dete filed (Mon	MATHU	32. Registe	rer's Signe	BOX 2	2729	, L.	A PLA	ATA,	MD.	20646				

DHMH 16 Rev 6/95

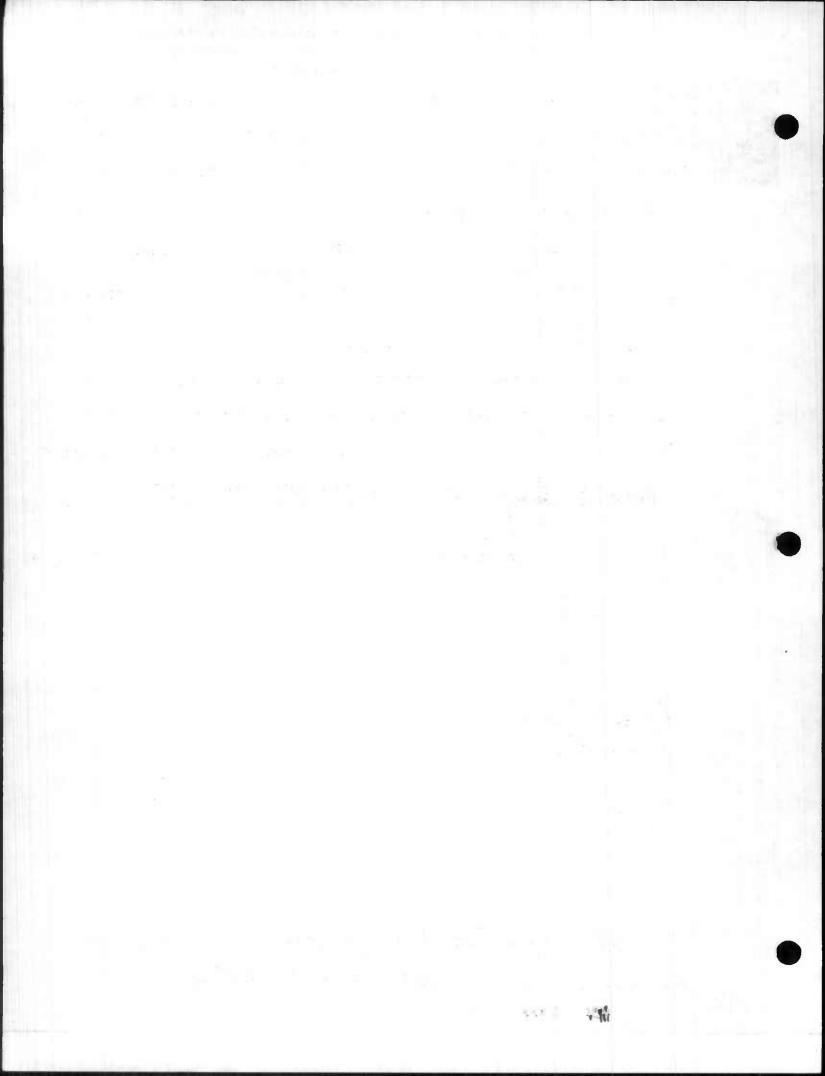


## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 10 pay 1999 ear BISER Virginia Leona 4:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner College View Center Frederick Frederick If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 1913 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** Deys 1□ M 🏋 217-16-2329 86 Yrs. Maryland Director Usual Residence of Decedent with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumatic event, the Medical Examiner must be notified at Maryland Frederick Frederick 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 113 East Sixth Street 21701 U.S.A. items 23a Funeral death 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 2 1 Vo If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. should be filed within 72 hours effer ond Mental Hygiene.
marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by White 3℃Widowed 4 □ Divorced Completed 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Waitress Restaurant permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked other any liquy or other traumatic event ADG. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) John STEWART Egar Elizabeth MOCK Rosie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Frederick Md. 21702 19a. Informant's Neme/Relationship (Type, Print) Mr. David Wayne Mills, Grandson 7114 Autum Leaf Lane, Frederick, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurlal 2 Cremetion 3 Removal from State Reformed Cemetery, March 12, 1999 Middletown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Fecility Keeney and Basford P.A. Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) unence **Examiner** Due to (or as a consequence of): Examiner attanding physician end for use es the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) P.O. I signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? cate has b paga 2 s certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica complately filled in by the funeral director, t 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Divatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and menner es steled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steled. Medicai 29a. Certifier 29b. Signature and title of partitler 29c. License number 29d. Date signed (Month, Dey, Year) March 10, 1999 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 300 v. 9th S) Frederik, molano, Tuneis 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death 1 Decedant's Nama (First Middle Lest) 2. Data of Daath 3. Tima of Death Month MARCH 11.40AM 4a. Facility Nama (If not institution, giva straat and number, 4b. City, Town, or Location of Death FREDERICK

If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth
(Month, Day,
Feb. 7 4c. County of Death HEALTH ARE FREDERICK FREDERICK 5. Social Sacurity Number Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) 1 M 2 F 79 004-16-4903 ME Usual Rasidance of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Kennebec Augusta 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? RR2 POB 11470 11460 Buttershill Terrace 04364 U.S.A. 14. Raca - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar In U,S Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 Navar Marriad 2 Married 1 ☐ Yas 2 No If Yas, Give Yaar or Datas: 1 ☐ Yas 2 No Specify: 3 Widowed 4 □ Divorced Specify: White 15. Decedant's Education (Specify only highast grada complated) 16e. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4nr 5+) Secretary Government 17. Fathar's Nama (First, Middle Last) 18. Mother's Nama (First, Middla, Meiden Sumama) Earl Ladd Effie Cummings 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Diane More/daughter 2010 Mt. Ephraim Rd. Adamstown, MD 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 A Cramation 3 ☐ Ramoval from Stata 3/10/99 Enders/Shirley F.H. 4 Donation 5 Other (Specify) Berryville, VA 22. Nama and Addrass of Facility Hilton Funeral Home Box 86 Barnesville, MD Approximete Interval Batween Onsat and Daath O YRS Dua to (or as a consequence of): Dua to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy parformed?

**Physician** /Medical Examiner

The law requires that the death certificete be axecuted

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

tem 27 is marked other then "natural", or items 23a or 28a-f show other traumstic event, the Medical Examiner must be notlined at

permit. Pages 1 and 2 should be filed within 72 hours efter c Department of Health and Mental Hygiene. Important: If tem 27 is merked other than "natural". or here any injury or other traument.

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Records,

Division of Vital

the Maryland

death v

attending physician end for usa as the burial-transit should be date cate has b To the Mospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification properties of the funeral director; the funeral director; the funeral director; the funeral director;

6

certificate

23a. Part 1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiretory errast, shock, or haart failure. List only one causa on aach lina. Immediata Causa (Final disaasa or condition rasulting in death) Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Be Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa ratarrad to medical 26. Place of Death (Check only ona) Othar: 4√2 Nursing Homa 5 ☐ Rasidenca 6 ☐ Othar (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Daath 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? 5 Panding Invastigation 1 Natural 1 🗆 Yas 2 No 2 Accident 3 Suicida 6 Could not be detarmined 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 Homleida Medical 29a Cartifian 1 🔀 Certifying Physicien: To tha best of my knowladga, daath occurred at tha tima, data and plece, end due to the cause(s) and mannar as steted. 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year)

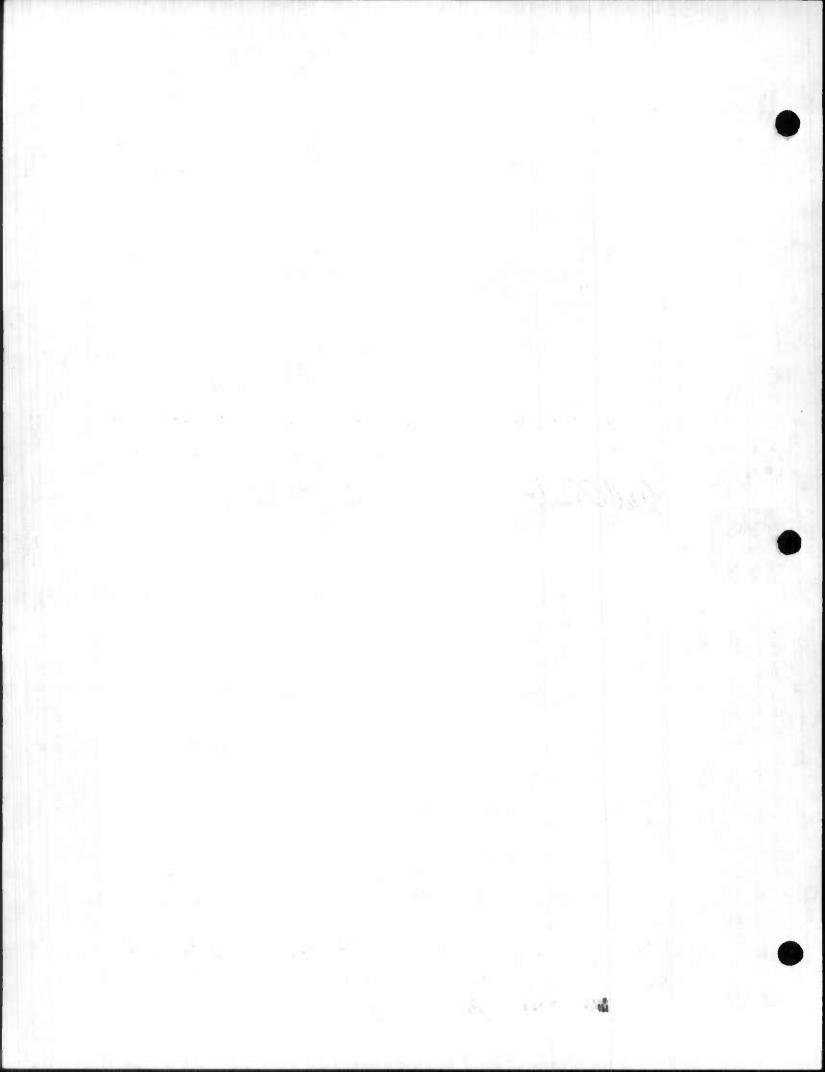
State Registrar

MD JARAVDRICA

30. Name and addrass of person who completed causa of daath (Item 23a) (Type, Print)



AUR BZOY FREDERICK MD 21702



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene WCHD/jrd Amended item #25 per M.E. 3/11/99 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Bolen, Jr. 2-26-99 Jason 10:50 Am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Baltimore Medical System University of Maryland If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□ F 3 MAR. 23, 1995 Director MARYLAND 218-43-6509 Usual Residence of Decedent the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at to Yes 2 □ No Director MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 210 CLOVER ST. U.S.A. 14. Race - American Indian, 21804 Funeral or Items : 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meritel Stetus Black White etc. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: p 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mentel Hygien, Important: if I fem 27 is marked other that any Injury or other trauments. NEVER WORKED N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JASON BOLEN, SR. **EDWARD** TAMMY MICHELLE BALDWIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Reletionship (Type, Print) JASON E. BOLEN, SR. -FATHER 210 CLOVER ST. SALISBURY. MD 21804 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cramation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) WICOMICO MEM. PARK SALISBURY, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility 705 E. MAIN ST. 21804 BOUNDS FUNERAL HOME, INC. SA

23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. SALISBURY MD Approximate Intervat Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition rasulting in death) brain Examiner carbon 0150n monoxide sicien and buriel-transit Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) inhalahan Smoke Box 68760, Physician/Medical Due to (or as a consequence of): \$ 88 house guip 23b. Did poeco use contribute to the cause of death? atten CERTIFICATION APPROVED TO Yes 25 No 3 Probably 4 Unknown for P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. signed by detacl Records. by 24b. Wera autopsy findings available prior to completion of cause of death? Completed 1 Yes 2 To 1 Tyes 2 □ No certificata Division of Vital 25. Wes case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera After 5 Pending investigation Injury 1 Natural 23/99 12:00 f.M. 1 Tes 2 PNo House tre 2 Accidant 6 Could not be determined 3 Suicide 286. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 302 Hammond St, Salishuy, Home edical ( 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO044627 2/26/99

Registrar

State

Elkridge, MD 21075

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

6372 Arbor

32. Registrar's Signature

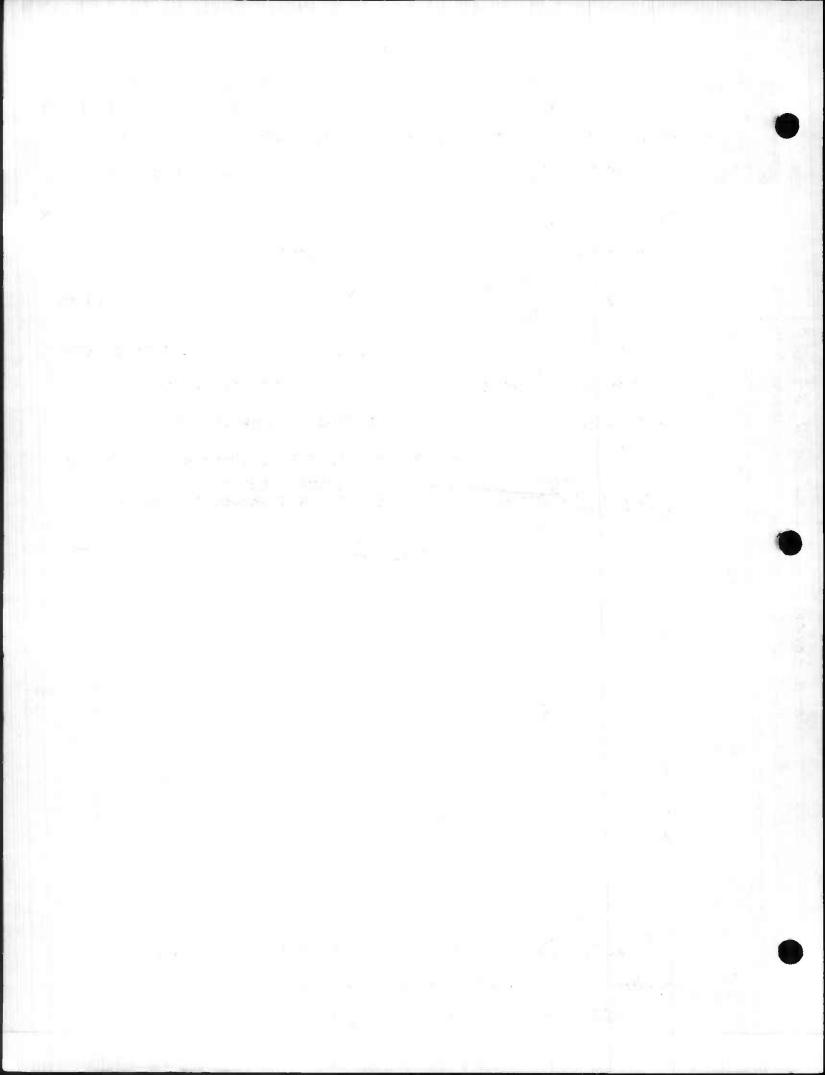
Robert Englander

MAR 0 9 1999

31. Dete filed (Month, Dey, Year)

			Decedent's Neme (First, Middle, Las	t)		Ce	rtifica	te of	Death	2. Dete of De	Reg. No.		3. Time of Deeth
	Physic /Medi	cal	JAMES JOHN	BARO					41 CT T	Month		1999	1954
٦	Exami	ner	4a. Fecility Neme (If not institution, give PENNINSULA REGION			ENTER			4b. City, Town, or SALISBUR		th 4c. County WICOM		
	Funeral Director		222-20-0079	9x 7 XM 2□ F	Age (In yrs. 53	last birthday, Yrs.	If Und Months	er 1 Yeer Deys	if Under 24 Hrs Hours Min	. (Month, De	rth ey, Yeer) ,1946		ce (Stete or Foreig AWARE
	/land		Usuel Residence of Decedent  10a. Stete 10b. County		10c. Ci	ity, Town or L	ocation					10d	I. Inside City Limits
	th with the Marylan 23a or 28a-f show	ctor	DE SUSS	EX		LEWES							1 ☐ Yes 2 No
	vith th	Dire	10e. Street and Number				10f. Z	ip Code			10g. Citizen of	-	177
	eath w	Funeral Director	10 RETZ LANE	12. Was Deced	lent Ever in I	IS 13	Was Dec		19968	Specify Ves or No		SA ce - American	Indian
020	filed within 72 hours after death with the Maryland Hygiena. ther than "natural", or items 23s or 28s-f show ent, the Medical Examinet must be indiffed at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Ford 1 Tes 2 If Yes, Give Yeer or Det	es? X No			ecify Cub	Hispenic Origin? (Sen, Mexican, Puer Specify:	to Rican, etc.)	Ble	ck, White, etc	
21215-0020	72 hours aff	Completed	15. Decadent's Ed (Specify only highest grad	ucation de completed)		16e. Dece	dent's Us	uel Occup	petion during most of wa	orkina	16b. Kind of B	usiness/Indus	stry
21215-0	within ena. than	mpi	Elementery/Secondary (0-12)	College (1-4	4or 5+)			use retire	during most of wo d)		COUNT	y GOV	ERMENT
) d	Hygi other	Be Co	17. Father's Name (First, Middle, Last)				OIC V	31010		me (First, Middle			EKMENT
ry ar	Wenta Menta urked	ToB	PASQUELE	BARON	E				LI	LYAN	BAGLIA		
Var 0	2 sho and la me		19e. informant's Name/Relationship (T	ype, Print)					end Number or R				ode)
lore, l	1 and Health		MARY MESSER  20e. Method of Disposition		20b. I	R-	-		J, GREE	ENWOOD,	DE . 1		n State
OE E	Pages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ i 4 ☐ Donetion 5 ☐ Other (Specify		ate	cemetery, cre	metory or	other ple	ATORY 3				
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiena. Important: if itam 27 is merked other than any Injury or other traumatic event, the Magnee.		21. Signeture of Funeral Service Linear						ass of Fecility AUER FU			DORT	HD
0	20 5 5 8		Hugarth						, GREEN			950	
9	Physician /Medical Examiner	je.	23a. Pert1. Enter the discuse, or comp shock, or heart tribute. List only of Immediate Cause (Final disease or condition resulting in death)	e		Asc or as a conse	V.	)				O O	oproximate intervel Between priset end Deeth
ox 68760,	requires that the death certificate be assouted been signed by the attending physician and hould be detached for use as the burial-transit	ın/Medicai Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Undertying Cause (Disease or Injury thet initieted events resulting in death) Last	b		or as a consec							
P.O. Box	it the death by the atter tached for	Physician/M	Pert II. Other eignificent conditions co	ntributing to dee	th but not res	sulting In the u	nderlying	cause giv	ven in Pert I.	23b. Did	tobseco use co	ntribute to th	he cause of death
1 5	es that the igned by t be datach	by Phy		DM						12	Yes 2□No	3 Probet	bły 4□Unknov
of Vital Record		Completed								24e. Wes	en eutopsy ormed?	evalla	e eutopsy findings able prior to pletion of cause ath?
a F	sician: The law certificate has t lirector, page 2 s									10	Yes 2 NONo	1 🗆 Y	res 2□ No
\ <u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u>	ysiciar is certifi directo	To Be	25. Wes case referred to medical exeminer?  1 Yes 2 No	Hospitel:	nationt 2	ER/Outpatler	nt 3 🗆 🖸	Oth	ar.	eth (Check only and the second of the second		nor (Specify)	
ion of	g Ph er th		27. Manner of Deeth  1 Neturel 5 Pending 2 Accident Investigation	28a. Dete of		28b. Time o Injury		28c. Injur Wor			how injury occur		
Division	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att complately filled in by the fur	Certification:	3 Suicide 6 Could not be 4 Homlclde determined	28e. Placa or building	f Injury - At h I, etc. (Specil	ome, farm, str	reet, fecto	ry, office		28f. Location ( City or To	(Street end Numb wn, Stete)	per or Rure! R	Route Number,
	Hospi 24 hou Funer Itely fill	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 Medical Exami	ner: On the basi	is of examina	owledge, death	occurred vestigetio	d et the tir n, in my o	me, date and plece	a, end due to the urred at the time,	ceuse(s) and ma date and place,	anner as stste and due to th	ed. ne cause(s)
	vithin vithin to the compla	Mec	29b. Signeture end title of parties	and menne	r steted.	_	25	9c. Licens	se number		29d. Dete signe	d (Month, Da	y, Year)
	- > - 0		· Chi Su	> 0.0.	Dr	NE		H	50497		31999		
	le		30. Name and address of person who co	empleted cause	of deeth (Iter	n 23e) (Type,	Print)	BIUF	¥ 20 .	SALISBUI	u mo		
	Sta	ate	31. Dete filed (Month, Day, Year)		gistrar's Signa	ature	,		FRD 3		//		

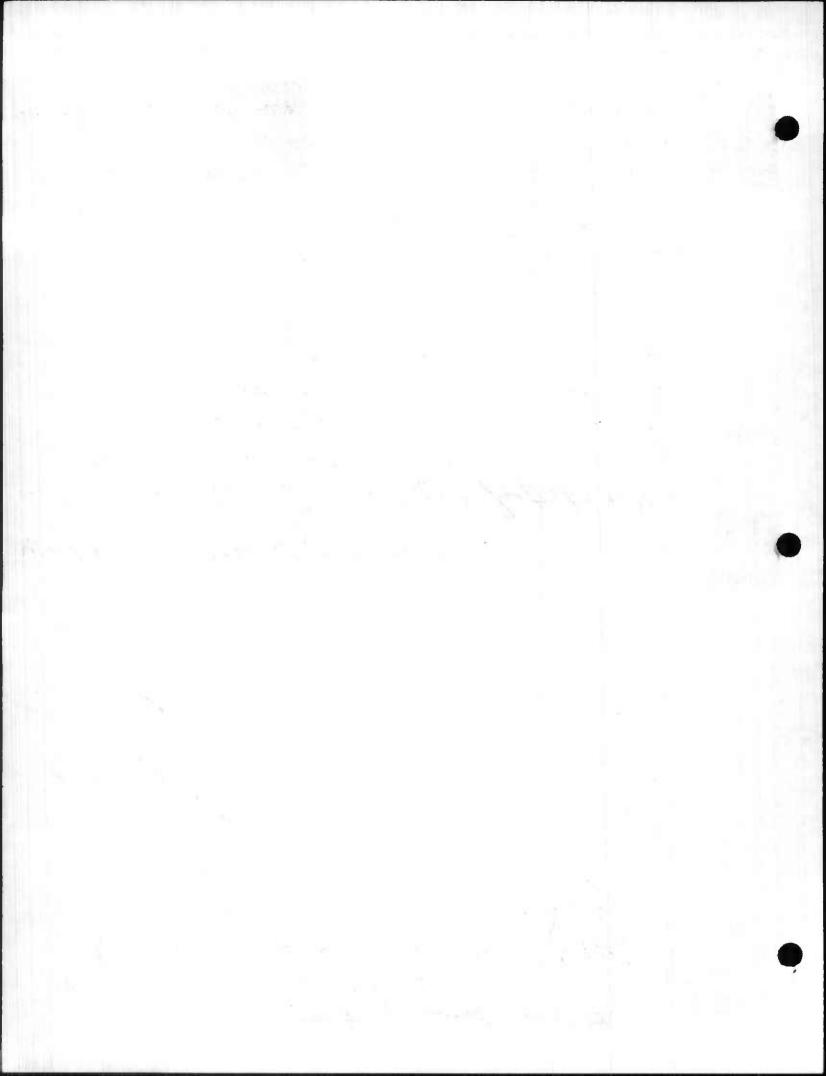
DHMH 16 Rsv 6/95



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 9 1 3 Certificate of Death

						Cert	ificate of	Death			Reg. No.		U.	7113
ľ	11		1. Decedent's Neme (First, Middle, L	ast)						Date of De	ath		V	3. Time of Death
	Physic /Medi		Russell Frank Bu	rton						Month Iarch	9. Day	1999	Year	8:45 p.m.
	Exami		4a. Facility Name (If not institution, g	ive street end number)				4b. City, Town	n, or Locati	on of Death	1 4c.	County of	f Deeth	
			20714 Wilkins La	ne (Residen	ce)			Rock H	[all		F	Kent		
	Funeral Director		5. Social Security Number 6. 155-42-4470  Usual Residence of Decedent	Sex 7. Age 1 ☑ M 2 ☐ F	(In yrs. lest birth	rday)_ rs.	If Under 1 Year Months Days		Min.	Date of Bird (Month, De ptembe	y, Year) r 16,		Countr	ce (State or Foreign y) elphia, PA
	and tand		10a. State 10b. County		10c. City, Town	or Loca	ation						10	d. Inside City Limits
	he Merylan Sa-f show otivised at	ector	Maryland Kent		Rock	Hal:								1 XYes 2 No
	23e or 2	Funeral Director	10e. Street and Number 20714 Wilkins La	ne			10f. Zip Code	L66 <b>1</b>			10g. Citi	izen of Wh SA	nat Countr	y?
21215-0020	72 hours efter death with the Meryland natural; or items 23s or 28s-f show dral Examiner must be notified at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates:	ver in U,S.		as Decedent of l Yes, specify Cub ☐ Yes 2 No		n? (Specify Puerto Rice	Yes or No an, etc.)		14. Race - Biack, Specify:	White, et	tc.
5-0	d within 72 hours liene. r than "natural", the Medical Exe	Completed	15. Decedent's (Specify only highest g	Education	16a. I	Decede	nt's Usual Occu	pation	of working		16b. Ki	ind of Busi	Iness/Indu	istry
21	- A	Idu	Elementary/Secondary (0-12)	College (1-4or 5-	F)		ind of work done O NOT use retire							
2	filed with Hygiene. ther than		12		Mari	ne &	Home Res				Mar			
Maryland	o la b	Be	17. Father's Name (First, Middle, Las	t)				18. Mother's	7.0		Meiden	Sumeme)	)	
Yla	should be nd Mental marked or umatic eve	2	Frank R. Burton					Mary B						
Jar	N 60 00 00		19e. Informant's Name/Relationship				Address (Stree					r Town, Si	tete, Zip C	kode)
	E = 81 F		Manick Burton/Wi	te			Wilkins					216		
altimore,	Pages 1 e nent of Hea nt: If Item iry or othe		20a. Method of Disposition  12 Burial 2 Cremation 3  4 Donation 5 Other (Spec				ition (Neme of etory or other ple apel Cen			.2/99		cation - Co	•	
Balti	permit. Pages I Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Lio	~1/1/	100	22.	Name and Addre	ess of Facility		NT.		,	1 77	D 4
			23a. Part1. Enter the disease, or co shock, or heart failure. List onl	npiications <b>tha</b> t caused to y one cause on each line	the death. Do no	13( ot enter	Speer the mode of dy	Road, ing, such as ca	Chest ardiac or re	ertor	n, N	1aryl	and	21620 Approximete Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Finel disease or condition		10BL									1 month
	Examiner	7	resulting in death)	0.	Due to (or as a co									
-	cuted nd ransit	Examiner	Sequentially list conditions.	b	Due to (or as a co	onsequ	ence of):						-	
68760,	icate be executed physician end s the buriel-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c									1	
Box 687	E 00	n/Medical	resulting in death) Last	D	oue to (or as a co	nseque	enca of):						1	
B	death ce	iclan	Part II Other elepiticant conditions	contributing to death but	and constitute in	the une	tach in a navan ai	ion in Doubl		125 Did	lahaasa			the cause of death?
0	the yy th	Physi	Part II. Other significant conditions	contributing to death but	not resulting in	tne und	ienying cause gr	ven in Part I.						
S, P	requires that the de seen signed by the e hould be deteched t	þ	0				-			1 🗆	Tes 2	□PNo 3	Probl	ably 4 Unknown
of Vital Records,	aw 2 S	Completed								24a. Was perfo	an eutop rmed?	isy	com	e autopsy findings lable prior to pletion of cause seth?
Œ	0 - 0	E O								10	Yes 2	3 No	1 🗆	Yes 22 No
ita	certificate rector, pag	Be C	25. Was case referred to medical					26. Place o	of Death (C	heck only a	ma)			
f V	5 w 0	ToE	examiner?	Hospital: 1 ☐ Inpatien	t 2 ER/Outs	patient	3□ DOA Ot	hor		5 Resid		8 □Other	(Specify)	
	Jing After fune		27. Menner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ According	28a. Dete of Injury (Month, Dey		me of jury	28c. Inju Wo		28d.	Describe I				
Division	or Attended efter deet Director:	Certification:	3 ☐ Sulcide 6 ☐ Could not determine	28e. Place of Injur building, etc.		n, stree	et, factory, offica	2.	28f.	Location (S City or Tox			or Rurel	Route Number,
	To the Hospital or Attent within 24 hours efter deet To the Funerel Director: completely filled in by the	edical C	29a Certifier 1 Certifying P	hysician: To the best of miner: On the basis of e	examination and	deeth o	occurred et the ti stigetion, in my	me, date and opinion, death	piece, and occurred a	due to the	cause(s) dete and	and manr piece, an	ner es sta id due to t	ted. he cause(s)
	within 2 To the	Me	29b Signature and title of certifier	0	ьи.		29c. Licens	se number	c.l.		29d. Dat	te signed (	(Month, D	ey, Year)
		6	30. Name and address of person who	completed cause of dea	ath (Item 23a) (T	ype, Pı	rint)	3605	7		3	11)	149	1
	Sta	te	Patrick J. Sha 31. Date filed (Month, Day, Year)	nahan, M 32. Registrar	D. 120	S	peer Ki	Suite	II (	hest	ertou	UN N	ND	21620
	Registr	-	MAR 11	1999	neva	B	· spa	els						

DHMH 16 Rsv 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month **Physician** Marianne Boessneck /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** North Arundel Hospital Glen Burnie 5. Social Security Number if Under 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1□ M 25 F Months Days Hours Min. 054-50-9650 89 Yrs. Director Usual Rasidanca of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show Director Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 715 Benfield Road Suite 311 21146 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 Yes 2 No If Yes, Give Year or Datas: 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 □ Divorced

Collaga (1-4or 5+)

15. Decedent's Education

(Specify only highest grade completed)

Elamantary/Sacondary (0-12)

17. Fathar's Name (First, Middle, Last)

Joseph Steidl

21. Signature of Funaral Sarvice License

19a. Informant's Name/Relationship (Type, Print)

Mary Anne Morrell / daughter

1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

12

20a. Method of Disposition

12.12 44 MARCH ,10 1999 4c. County of Death Anne Arundel 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Feb. 1,1910 Germany 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, Whita, etc. Specify: White 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Own home 18. Mother's Name (First, Middle, Maidan Sumame) Gisela Novotny 19b. Malling Addrass (Straet and Number or Rural Routa Number, City or Town, State, Zip Code) Edgewater, Md. 20c. Location - City or Town, State 3-15-99 Brentwood, Md. 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

3. Time of Death

**Physician** /Medical

other traumatic event,

Pages 1 end 2 should be nent of Health and Mental int: If Item 27 is marked or

N GOLDANNA

**Examiner** Physician/Medical Examiner

pue

physician

certificate

After this

s efter death.

To the Hospital within 24 hours e

filled in by

by

Completed

Be

Lo

Medical

The law requires that the death certificete be executed

68760.

P.0.

Records,

of Vital

or Attending Physician:

Sequentially list conditions, if any, leading to immediate causa. Enter Undarlying Cause (Diseasa or Injury that initiated events resulting in death) Last

Immadiata Cause (Final diseasa or condition resulting in daath)

MYOGARDIAZ INFARCTION (pububle)

Homemaker

3707 Bayport Dr.

20b. Place of Disposition (Name of cemetery, cramatory or other place)

Ft. Lincoln Crematory

Due to (or as a consaquance of):

Dua to (or as a consequance of):

t II.	Other significant conditions contributing to death but n	not resulting in the underlying	cause given in Part I.	
	Chronic Instructive	Perlumany	Disease	,
-	Early Deventia			
_	- 410 SYNCOPY			

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy parformed?

24b. Ware autopsy findings available prior to complation of cause of death?

1 ☐ Yes 24 No

26. Place of Daath (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify)

1 ☐ Yas 2 ☐ No

25. Was case referred to medical 1 Yas 2 No 27. Manner of Death

Natural

3 Suicide

5 Pending invastigation 2 Accidant

28a. Date of Injury (Month, Day Year)

Hospital: 1/2 Inpatient 2 ER/Outpatient 3 DOA 28b. Tima of

28c. Injury at Work? 1 Yes 2 No 28d. Dascribe how injury occurred

6 Could not be detarmined 28e. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 I Homicida 29a. Cartifiar

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check o 29b. Signatu

29c. Licansa number D51245

29d. Date signed (Month, Day, Year) MARCH 10,1999

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print)

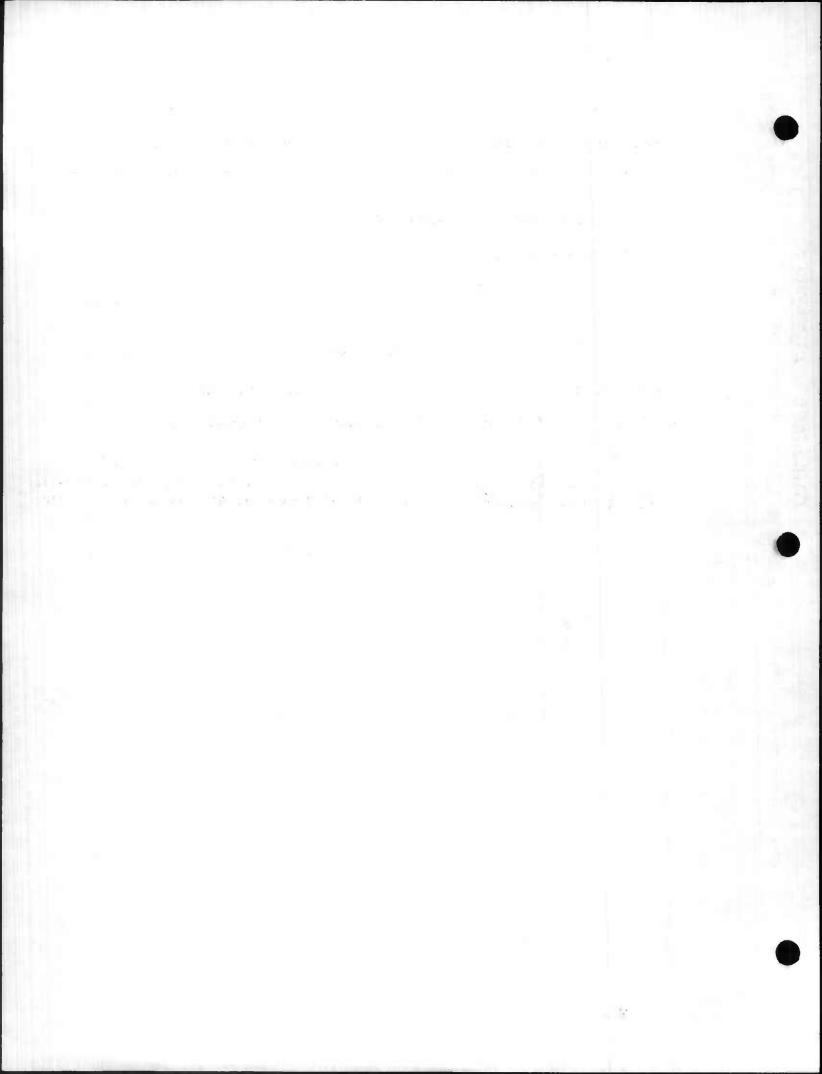
SHARLF 31. Data filed (Month, Day, Year)

NORTH MUNDER

State Registrar

MAR 1 2 1999

buspiton - MI 32. Pegistrar's Signature



State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month BENTON MAR 1999 1210

**Physician** /Medical **Examiner** 

altimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

of Vital

Division

Hospital

the

physician and s the buriel-transit 98 signed by the page 2 s this funeral Certification: After death. filled in by the within 24 hours after deal To the Funeral Director:

Medical

State Registrar

completely

HAZEL 4e. Fecility Nama (If not institution, giva street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth AA Timbertidge Dr. HANOVEY If Undar 24 Hrs. 8. Deta of Birth (Month, Dey, Year) If Undar 1 Yaar 5. Social Security Numbe 7. Age (In yrs. last birthdey) **Funeral**  Birthplaca (State or Foreign Country) 1 □ M 2 X F 238-34-5621 Yrs. Director 70 OCT. 26,1928 NORTH CAROLINA Usuet Residence of Decedent 10e. Stete 10b County 10c. City. Town or Location r than "natural", or itsms 23s or 28s-f show the Medical Examiner must be notified at 10d. Insida City Limits 1 Yes AN No Director MARYLAND ANNE ARUNDEL HANOVER 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 912 TIMBER RIDGE DRIVE 21076 U.S.A. death 12. Was Decedent Evar In U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yaar or Detes: Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indien, Black, White, etc. after 1 Never Merried 2 Marriad 1 Yes 2√ No Specify: WHITE by Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done duning most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) t 6b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 12 WESTINGHOUSE MULTIPLE LIFT OPERATOR permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Itam 27 is marked othe any liqury or other treumstic svent 200s. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) NORMAN HERALD CARPENTER ETHEL MAE SLOAN 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) (HUSBAND) NORMAN BENTON 912 TIMBER RIDGE DRIVE, HANOVER, MD. 21076 20b. Plece of Disposition (Neme of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from State 5 Other (Specify) 4 Donetion CHELETENHAM CEMETERY 3/11/99 CHELTENHAM, MD. 21. Signature of Figural Service Licenses 22. Name end Addrass of Fecility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each tine. Onset and Deeth **Physician** /Medical Immediate Cause (Final diseasa or condition resulting in deeth) Examiner Examiner Heart Disense terio solerofic the death certificate be executed Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated avents resulting in deeth) Lest 1 fluenza Physician/Medicai Due to (or as a consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nunknown þ 24b. Were eutopsy findings evelleble prior to completion of causa of death? Completed 24a. Wes en eutopsy performed? The lew 1 Yas 2 No Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigetion or Attending 1 Maturel 1 ☐ Yes 2 ☐ No 2 Accident

> 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.
>
> Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner steted. 29b. Signeture end title of certifier 29c. License number Deputy 29d. Dete signed (Month, Dey, Year) mD

30. Neme end eddress of person who comple

3 Suicide

4 Homicide

31. Dete filed (Month, Day, Year) MAR 1 0 1999

6 Could not be

MO Registrer's Signeture

28e. Ptece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

use of deeth (Item 23e) (Type, Print)

28f. Location (Straat and Number or Rural Route Number, City or 7 Jwn, State)

**DHMH 16 Ray 6/95** 

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death Reg. No.

					Ce	ertifica	te of	Death			Reg. No.		
		ne (First, Middle, La	rcher						1	2. Dete of De	eth Dey	Yeer	3. Time of Death
Physician /Medical	Lorraine	kay bi	TCHEL						/	Yorch	- 07	1999	9:30 an
Examiner	4e Facility Neme North Ar	(If not institution, giver rundel Hos	e street end nu spital	m <i>ber)</i>				4b. City, To Len B		ation of Deat	4c. Count	y of Deeth Arur	ndel
Funeral Director	5. Sociel Security 228-74-6		ex □M:2⊠TF	7. Age (In yrs		Months	Days	If Under Hours	Min. O	B. Date of Bi Month, De CT 20,	1931	9. Birthp Coun Mass	elece (State or Foreign eachusetts
D ×	Usuel Residenca	of Decedent 10b. County		100 0	ity, Town or L	ocation						1	Od. Insida City Limits
tha Marylar 28a-f show notified at	MD	Anne Ar	undel		everna	Park						,	1 □ Yas 2 🗷 No
death with the Maryland me 23e or 28e-f show relate to notified at	10e. Street end No 691 Wel	lerburn A	venue				ip Code 146				10g. Citizen of USA	Whet Coun	itry?
urs aftar bl., or its Example by Fui		rrled 2⊠ Married 4 □ Divorcad	12. Was Dec Armed Fo 1 Tes If Yes, Gi Yaar or D	2X No	J,S. 13	Was Dec If Yas, sp	ecify Cub	lispenic Orlan, Mexicar Specify:	n, Puerto R	ify Yes or No ican, etc.)		ca - Americ ick, White, fy:	
"natural", adical Ex	(Spe	15. Decedent's Ed			16e. Deci	edent's Us	uel Occup	etion during mos d)	t of working	7	16b. Kind of B	Business/Inc	dustry
	Elementary/Sec		College (			enake		d)			Home		16.5
d out Heli		o (First, Middla, Last, core Luppi							er's Neme (		a, Maiden Sumei CNOWN )	ma)	
d 2 shouth and Muth a		Neme/Reletionship (		r							per, City or Town		
permit. Pegas 1 and 2 should Department of Health and Mar Important: If fem 27 is marke any injury or other traumetic once.	20e. Method of Dis	sposition	Ramoval from	20b. Stata	Plece of Disp camatery, cr	position (Nematory or	eme of other ple	ca)	Mai	Dete C 15	20c. Location Arlin	- City or To	own, Stata
permit. Pegas 'Department of Filmportant: if the any injury or of of once.		5 Other (Specificant) Secured Light		Al	lingto	22. Nama a	nd Addra	ss of Fecilit	tv		orna Par	ck Fur	neral Home
82 5 8	1 th	41	Dun										VIC 21146
	23a. Party. Enter	the disease, or com art failure. List only	one ceuse on	caused the dee each line.	eth. Do not e	nter the mo	de of dyi	ng, such as	cardiec or	respiretory a	arrest,		Approximate Interval Between Onset end Death
Physician // // // // // // // // // // // // //	Immediata Causa	(Finel		7 ,		0.	0	_	) (	1			0 0
Examiner	disease or conditi resulting in death	ion	0	enhon	or es e conse	ioxic	le	14	eten	hien		- 1	2 days
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that the ded by the detach											¥es 2□No		bably 4 Unknow
been si should										24a. Wes	s an autopsy ormed?	ev	ere autopsy findings reliable prior to empletion of causa death?
The law page 2										10	Yes 2 No	10	☐ Yes 2☐ No
ysician: The scartificeta diractor, pag	25. Wes case refe exeminer?	erred to medical							of Death	(Check only	one)		
T dig	1 ☐ Yes 2 ☑	LHO	Hospitel: 1 [2	Inpatient 2	☐ ER/Outpetid	ent 3 🗆 🛭	NOA		-		idenca 6 □Ot		5/)
Prat D	27. Menner of Dea 1 Maturel 2 Accident	5 Pending investigation	n	of Injury oth, Dey Year)	28b. Time Injury	of M	28c. Inju Wo 1 🗆	ryet rk? Yes 2 □		3d. Describe	how injury occu	irred	
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	3 Suicide 4 Homicide	6 Could not b determined	200. FIECE	of injury - At I ing, etc. (Spec	nome, farm, s ify)	treet, facto	ory, office		21		(Street end Num own, Stete)	ber or Rurs	al Route Number,
he Hospita in 24 houn he Funera pletely fills edical (	29a. Cartifiar (Check only one)	1 Certifying Ph 2 Medical Exam	niner: On tha b										
Nethin Youth	29b. Signeture en	d title of certifier	2 5	1-		2	9c. Licens	a number			29d. Data sign	ed (Month,	Dey, Year)
->-0	19	7-17	Saya	1			7	5101	0		March	, 0	7, 1999
	30. Name end add	manail-	completed cau	se of death (Ite	m 23a) (Type	441)	91	MID	- n	1.th	1 Ann	let	Hosp.
State	31. Dete filed (Mo	nth, Dey, Year)		Registrer's Sign	eture		,						

Lorraine R. Bircher

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				Cei	rtificate	of De	eath			Reg. No.	7 0	311	1
	II	Decedent's Neme (First, Middle,	Last)		110				2. Dete of De		Vene	3. Tima of I	Death
	Physician /Medical	Harry W	Black						March	5, 19	99	12:1	5am
	Examiner	do Footlib, Name (Mant Institution)	give street end number)	H P E		4b. (	City, Tov	vn, or Le	ocation of Deeth		ty of Deeth		
	- Laminiei		Medical Cen	ter		Ar	nnar	ooli	is		Anne	Arun	del
_	Funeral		Sex 7. Age (In yrs.		If Under 1 Y	eer If	f Under 2	24 Hrs.	9 Date of Bir	th	I o Dieb	alana (Ctata a	
	Director	214-03-7748	1≅M 2□F 84	Yrs.	Months D	ays I	Hours	Min.	Sept S	y, Year) , 1914	Mary	land	
	pug *	Usuel Residence of Decedent  10e. State 10b. County	10c. Cif	ty, Town or Lo	cation							10d. Inside Cit	v f imits
	after death with the Marylar or items 23e or 28e-f show printed mortified at / Funeral Director		e Arundel Arn									1 🗆 Yes	
	or 28a-f all be notified	10e. Street and Number			10f. Zip Co	de				10g. Citizen of	What Cou	ntry?	
	h with	465 Manor Roa	d		21012	2				US	A		
	r items 234	11, Meritel Stetus	12. Was Decedent Ever in U	,S. 13. \	Wes Decedent	of Hispa	anic Ong	pin? (Sp	ecify Yes or No		ce - Americ		
020	E	3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Yeer or Detes:		If Yes, specify		Mexican, Specify:	, Pueno	rican, etc.)		ack, White, ity: Whit		
21215-0020	ed within 72 hours ygiene. Ner than "natural", It, the Medical Ex Completed by	15. Decedent's (Specify only highest)	Education grade completed)	(Give	dent's Usuel O kind of work d	one duri	on ing most	of work	ing	16b Kind of I	Business/in	dustry Juipmen	t
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12	offied withing the Hygiene. other than vent, me		net	Maci	IIIIISC	10	Atotho	do Nom	e (First, Middle,				
ian	SES M	Franklin Ber	•						nknown)	Maiden Sume	me)		
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Baitimore,	- 7 5 5	20e. Method of Disposition 1 ⊠ Burial 2 □ Cremetion 3		Plece of Dispo	sition (Neme o	plece)		IN	late 8	20c. Location	,		
Ë	permit. Pages Department of I Important: If its any Injury or o	4 Donetion 5 Other (Spe	T .	oudon I	Park Ce	mete	ery	i	1999	Balti	nore,	MD	
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		23e. Perry. Enter the diseese, or co shock, or heert feilure. List or	implications that caused the deet	h. Do not ente	er the mode of	Rit dying, s	such es	e Hy	or respiretory e	rerna Pa	ark,	MD 2114 Approximate	9
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	j		Due to (d	or es e conseq	juence of):		-						
	minsit insit		b								i	*	101
6	death certificate be executed a stending physician and ad for use as the bunal-trensit sician/Medical Examines	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (o	or as a conseq	juence of):								
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289	ficate be physicia as the bur edical	resulting in death) Last	Due to (o	r es e conseq	uence of):								
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o.	net the death or d by the attend letached for us Physician/	Pert ff. Other significant conditions	contributing to death but not res	ulting in the ur	nderlying caus	e given i	in Pert I.		23b. Did	tobacco use c		١.	
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Division of	xesc t	4 ☐ Homicide determine	28e. Plece of Injury - At he building, etc. (Specifi	y)	eet, fectory, of	IICO			28f. Location (: City or To		100r or Hur	ai Houte Numt	)0r,
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	(Check only one)	aminer: On the basis of examiner end menner stated	tion and/or inv	estigation, in	ny opini	ion, deet	h occur	ed at the time,	date end plece	, and due t	to the cause(s)	
	outh outh		0/11	)	29c. Li	cense nu	umber	-		29d. Date sign	ed (Month,	Day, Year)	
	->-0	) (//// b	1611	/	7	41	816			3	15/	99	
		30. Name and address of person wh	a completed course of delay (1)	02a) /T		/ '			/	- //	1	1	
		Charles W. Phan	o completed cause of deleth (Item	(1ype,	M.J	1/	1-	fare	Ann	-rembli	4 JT	1211	0/
	State	31. Dete filed (Month, Dey, Year)	32. Regultrar's Signa	iture #		/ [	- 04/		Hun	10/15	MU	2140	7
	State Registrar	MAR 0 8	1999	1 13.	100	all.							

There is a fine

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day Elbert Totten Broadwater Feb. 28, 1999 8:00 AM 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth 23512 McMullen Hwy, SW RAWlings If Under 24 Hrs. 8 Hours Min. Allegany Birthplaca (Stete or Foreign Country) 5. Sociaf Security Number If Under 1 Yeer 8. Date of Birth (Month, Dey, Year) 6 Sex 7. Age (In vrs. last birthdev) ₩ 2□ F Months Days 82 Sept. 9, 219-03-8308 1916 Maryland Usuel Residence of Deceden 10c. City, Town or Location 10b. County 10d. Inside City Limits Allegany 1 Yes 20No Rawlings 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23512 McMullen Hwy, SW 21557 United States 12, Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Raca - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritei Status 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Westvaco Unknown Main Lab Tech Service 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Mortimore Broadwater Ida Bittinger 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Elbert Broadwater, Jr / Son 23512 McMullen Hwy, SW Rawlings, MD 21557 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete popurial 2 ☐ Cremation 3 ☐ Removal from State Westernport, MD 4 Donetion 5 Other (Specify) Philos Cemetery 3/2/99 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 111 Church St. 7-20 ayre Boal Funeral Home Westernport, MD 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting In death) Due to (or as a Sequentielly list conditions, it any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Was an autopsy 1 Yes 2 No

**Physician** /Medical Examiner

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ettending physician

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signed by I

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certificate

funeral director,

Be

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Certification:

Medical

Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certific

To the Hospital of within 24 hours e To the Funeral D

law requires that the death certificate be executed

P.O. Box 68760

Records,

Division of Vital

**Physician** 

/Medical

Examiner

10e State

**Funeral** 

Director

28a-f show

Directo

Funeral

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Completed

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7 is marked other than "naturel", or items 23s or 28s-f shov treumstic event, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filled within 72 hours effer a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other treumatic event, the Medical Experimentals.

Baltimore, Maryland 21215-0020

with the Marylend

death

Examiner Physician/Medical þ Completed

Pert II. Other significant conditions copyributing to death but not resulting in the underlying cause given in Part I.

26. Place of Deeth (Check only one)

1 Yes 2 No

25.	Was	case	referred	to	medical	
	exam	niner?				
	101	Yes	24 No			

27. Manner of Death Naturel 2 Accident 5 Pending investigation

6 Could not be determined

28e. Date of Injury (Month, Dey Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home SAResidenca 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a, Certifier

3 Suicide

4 Homicide

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner as steled.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

una certifier 29b. Signatu 4.7. 29c, License number

29d. Date signed (Month, Dey, Year)

March 1, 1999

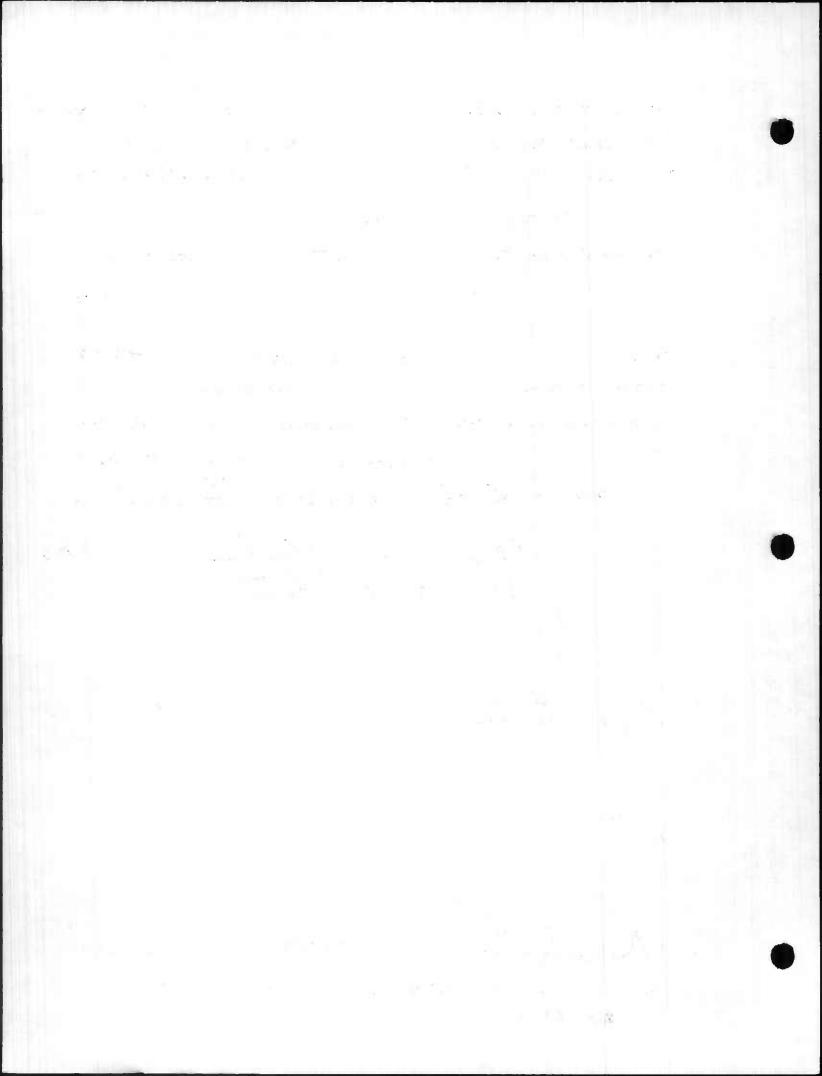
30. Name and address of person who completed cause of deeth (item 23a) (Type, Print)

State Registrar Robert W. Bess, Jr. 31. Date filed (Month, Dey, Year)

MAR - 2 1999

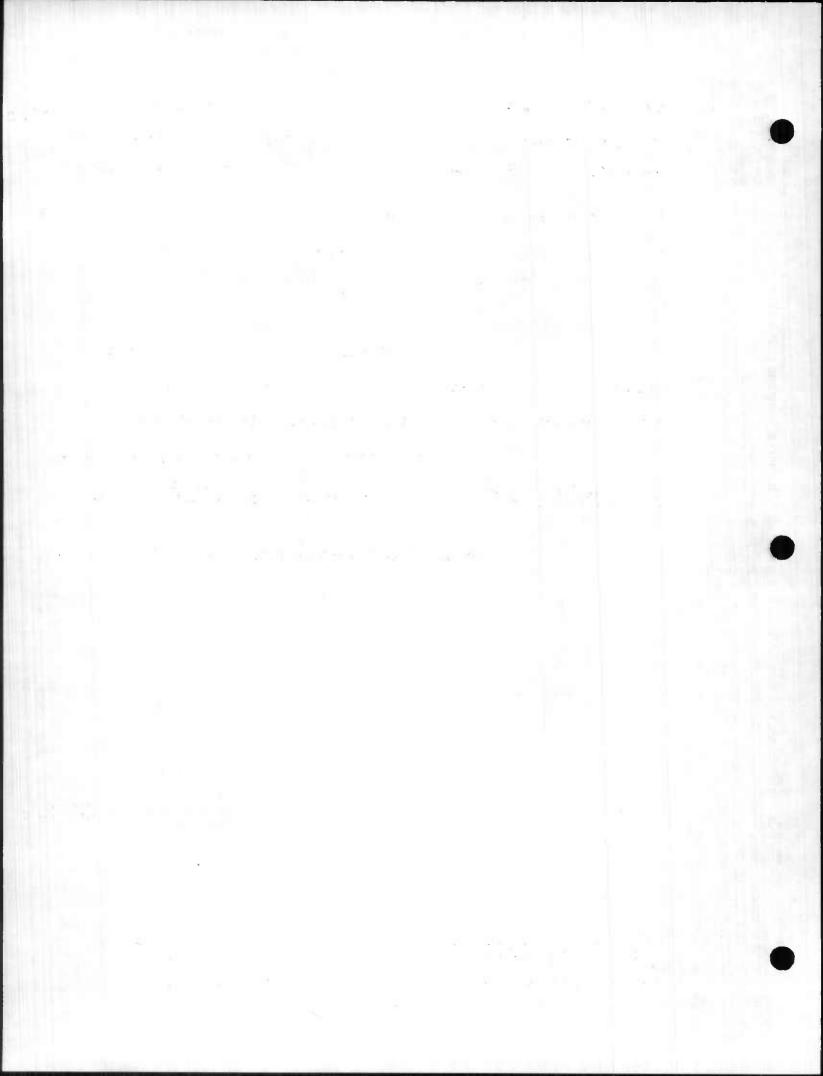
32. Registrer's Signeture

122 Ashfield St. Piedmont, WV 26750

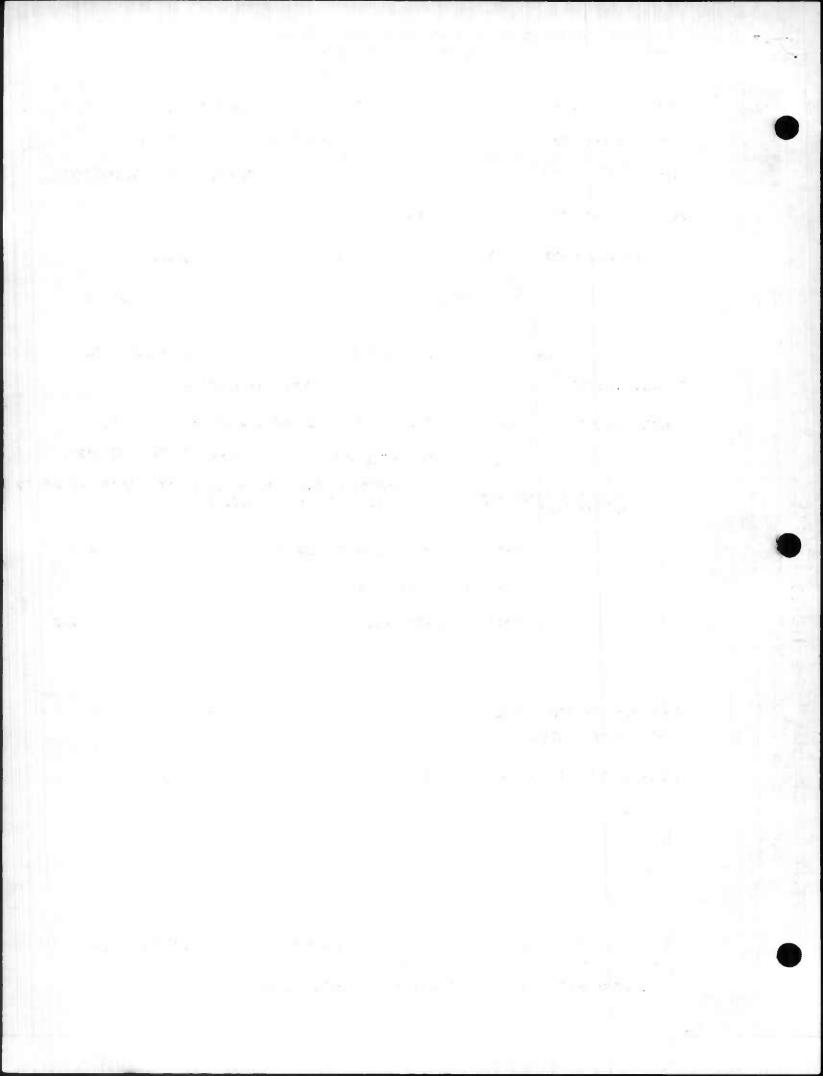


State of Maryland / Department of Health and Mental Hygiene 9 9 1 1 9

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Dir		and Number	Dry Do	4 D			,	Of. Zip		1				itizen of W	net Coun	try?	
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			Decedant's Nem	a (First Middle 1	ast)			Certifica	te of	Death	2. Data of D	Reg. No.		3. Timui i	of Though
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Fun	erai		5. Social Sacurity N		Sex		yrs. last birth	day) If Unde	or 1 Yea		8. Date of B	irth	9. Birthple	aca (State	or Foreign
Dire	ctor	1	536-14-60		1(XM 2□ F	74	Yı	s.	Day	TIOUIS WIII.	MARCH	28, 1924	WASHI	NGTO	Ŋ
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d 21215-0020 filed within 72 hours after death with the Marylend thygiena. ther than "natural", or items 23a or 28a4 show	Tour L	by Funeral Director	10e. Street end Nur	mber				10f. Z	ip Coda			10g. Citizen of	Whet Countr	ry?	
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21215-0020 d within 72 hours aff giena.			3 LJ 11100460	15. Decedant's E	Year or	Datas:	16a D	ecedant's Us	ual Occi	unation		16b. Kind of B	usinass/Indu	istry	
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			23a. Part 1. Enter t	ha disease, or con rt feilura. List only	plications that	caused the	death. Do no			Ing, such as cardiac			1 9	Approxima	ite
Physic			SHOCK, QVIIO	it leliula. List Offi	ona cause on	eech iina.								Onsat and	Death
/Medi Exami	_		Immediata Cause ( disaesa or conditio	Final n	ACU	TE RES	PIRATO	RY INS	UFF	ICIENCY			H	OURS	
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COIDS, T.O. BOX 68/60, v requires that the death certificate be asscuted been signed by the attending physician and	bed f	Physician/Med	Part II. Other eignif	icant conditions	contributing to	death but not	t rasulting in t	ha undarlying	causa g	ivan in Part I.	23b. Dio	i tobacco usa co	ntributa to 1	the cause	of death?
thet the	detac	7	LEFT HEN	MISPHERIC	STROK	E					TX.	Yes 2 No	3 Probe	ably 4	] Unknown
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			4 Homicide	datarmined	20a. Flat	ce of Injury - Adding, atc. (Sp.	At home, ferm pec <i>ify)</i>	i, straat, facto	ry, office		28f. Location City or To	(Street end Numi own, Stata)	ber or Rural	Routa Nur	nber,
Hospital 24 hours Funeral			29a. Certifiar	1V Cartifying Di	velcien: To th	a hast of mu	knowledge	leath cocurre	i at the t	time, date end placa	and due to the	course(s) and -	enner en el -	tod	
24 h	pletely fil	2010	(Check only one)	2 Medical Exa	miner: On the	basis of axan basis of axan nnar statad.	nination and/	or Investigation	n, in my	opinion, death occu	rred at tha tima	, data and place,	and dua to t	ha causa(	s)
To the Within 2	d Eoo		29b. Signatura and	title of certifie		M	/	29	c. Lican	nsa number		29d. Dete signe	d (Month, D	ay, Yaar)	
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12		;	30. Nama end addra	ass/of person who	completed cau	use of deeth (	(Itam 23a) (T)	Pe, Print)							
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Red	gistraı	r	- IV	IAR 0 8 1	<b>フ</b> フフ			V. 10	VOL	12/					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Deeth Month **Physician** 1999 Ursula M. Carroll March 3, 3:25 PM /Medical 4c. County of Death

Amend #5,3/17/99,BMW,Montg.Co 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2 K F Months Days Houra Yrs Director 68 Sept. 15, 1930 Usual Residence of Decedent the Merylend 10a State 10b. Count 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Madical Examinat must be notified at Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5920 Ridgway Avenue 20851 United States death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within: Depertment of Health and Mental Hygiene. important: if leam 27 is marked other than any injury or other traumath. Elemantary/Secondary (0-12) Collaga (1-4or 5+) 12 Accounting Specialist Computer Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Franz Joseph Barisch Hedwig Barisch 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Ray E. Carroll/Husband 5920 Ridgway Avenue, Rockville, Maryland 20851 20b. Place of Disposition (Name of cemetery, crematory or other place March 8, 1999 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) John's Church Cemetery 21. Signeture of Funeral Service Licensee M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast shock, or he in failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final Examiner

Beltsville, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

disease or condition rasulting in death) a Metastatic Carcinoma of Lung, non small cell Dua to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseasa or Injury that initiated avants resulting in daath) Last Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Part i.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2□ No 3□ Probably 4□ Unknown

March 4, 1999

24a. Wes an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Approximata Interval Between Onset and Death

2 months

Birthpiace (State or Foreign Country)

10d. Inside City Limits

1 X Yes 2 No

Germany

White

26. Placa of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes 2K No

1 ☑ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred

1 Yes 2 No 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, State)

D04602

1 Certifying Phyaiclan: To the best of my knowledge, daath occurred at tha time, data and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basts of examination and/or invastigation, in my opinion, death occurred at tha time, date and place, and due to the causa(s) and mannar stated. 29a. Cartifiai (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer)

30. Name and address of person who completed ceusa of death (Item 23a) (Type, Print)

Jeremy V. Cooke, M.D. 10400 Connecticut Avenue, Kensington, Maryland

State Registrar

Examiner

Physician/Medical

by

Completed

Be

7

Certification:

Medicai

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

1 X Natural

2 Accident

3 ☐ Suicide

4 Homicide

certificate be executed

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Records.

Vital 3

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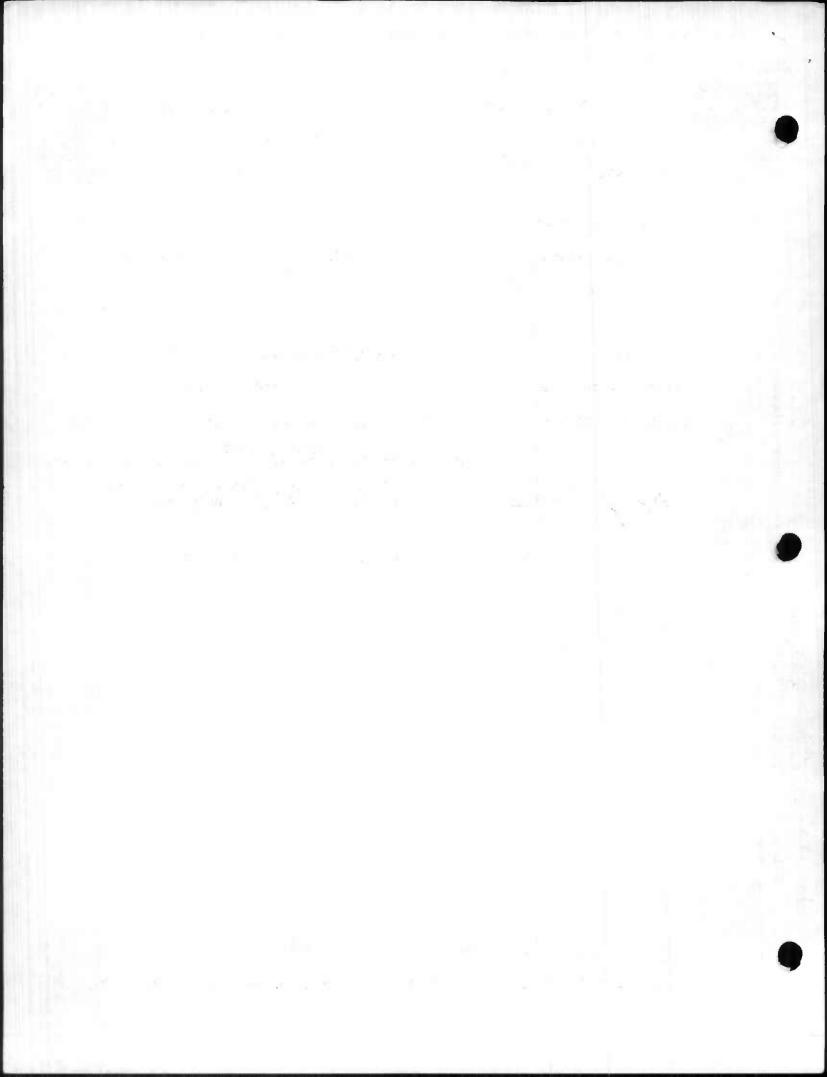
> 31. Date filed (Month, Day, Year) MAR 08

5 Panding invastigation

6 Could not be detarmined







State of Maryland / Department of Health and Mental Hygiene O

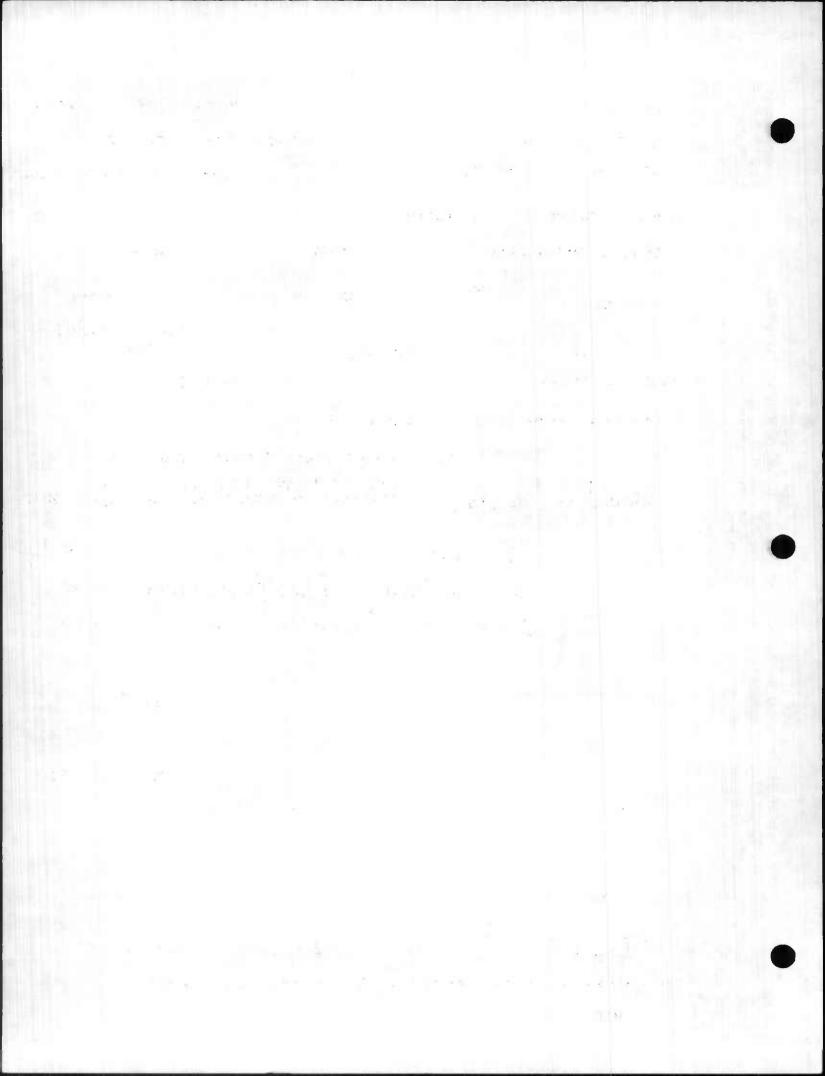
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death <sup>Dey</sup>1999 March 7, **Physician** 8:20A. Mary A. Caudle /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Bayside Care Center Lexington Park St. Mary's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 1 □ M 25 F 577-22-0349 76 Yrs Director March10,1922 Washington, D.C Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show odical Examiner must be notified at Calvert. 1 ☐ Yes 2000 Maryland Owings Directo 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? 2101 Lower Marlboro Road 20736 United States Pages 1 and 2 should be filed within 72 hours efter death a neat of Health and Mental Hygiene.

This If Hear 27 is marked other than "natural", or Items 23, with It is the other traumatic event, the Medical Exam for mall any or other traumatic event, the Medical Exam for mall. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ▼ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: White þ 3 Widowed XX Divorced Completed 16e. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) National Education Elemantary/Secondary (0-12) College (1-4or 5+) Association Secretary 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Be LeRoy R. Sidney Marie E. Gray 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) George David Caudle (son) 20b. Plece of Disposition (Neme of cemetery, crametory or other plece) Date 20c. Location - City or Town, State 20e. Method of Disposition XX Buriat 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Fort Lincoln Cemetery 3/9/1999 Brentwood, Maryland 21. Signature of Funerei Service License Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the deeth. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sech line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in daath) Examiner Examiner The law requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai attanding pl Pert II. Other eignificant conditions contributing to death but not resulting in tha undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown by should b 24b. Were autopsy findings aveileble prior to completion of cause of daath? Completed 24e. Was an autopsy page 2 2XX10 1 Yes XXNo 1 Yes certificate Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica director. Be 25. Was case raferred to medical 26. Place of Death (Check only one) Other: Wursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XXVo 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1 XX atural 5 Pending Investigation 2 No 1 Yes 2 ☐ Accident To the Hospital or Atter within 24 hours after des To the Funeral Director completaly filled in by th 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicida \*\*Certifying Physicfan: To the best of my knowledga, deeth occurred et the time, dete end plece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, daeth occurred at the time, data and plece, and due to the ceuse(s) end manner stated. edical 29a, Certifier 29b. Signature and title of certifie 29d. Dete signed (Month, Day, Year) 29c. License number March 8, 1999 30. Neme end eddress of person who complated cause of death (Itam 234) (Type, Print) David Allen, M.D. 22815 Washington St. Leonardtown, Maryland 20650 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State MAR 1 1 1999

**DHMH 16 Bev 6/95** 

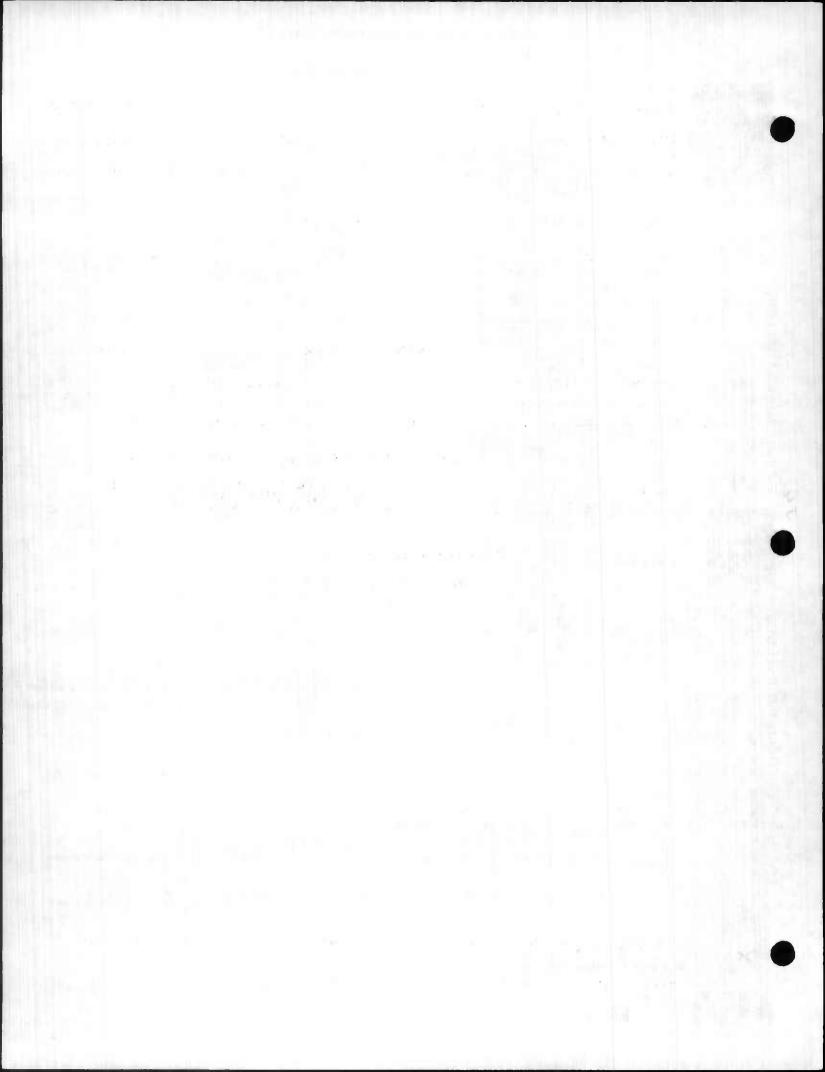
Registrar



State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Nama	First, Middla, Last,	)						2.	Data of Dea	-	Ve	3. Time of Death
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edicai miner	4a Facility Nama (If n			er)						ion of Death	4c. County	of Death	
	Holy Cross	s Hospita	1				S		Sprin	-	Montg	omery	
ral tor	5. Social Security Nur 186–32–47		7. AM 2 F	Aga (In yrs. 57	last birthday) Yrs.	If Und Months	ar 1 Year Days	If Undar 2 Hours	Min. Ju	Data of Birth (Month, Day ne 5,	Year) 1941	9. Birthpi Count Penn	ace (Stata or Foreig try) sylvania
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by Funeral Director	11. Marital Status  1 Navar Married  3 Widowed 4	2 X Married	12. Was Deceda Armed Forca 1  Yas 2 If Yas, Giva Yaar or Data	s? XNo		Vas Dec I Yas, sp	edent of H ecify Cuba	lispanic Orig an, Maxican Spacify:	gin? (Specify , Puarto Ric	/ Yas or No- an, etc.)	14. Red Blac	e - America ck, Whita, a y: Whi	atc.
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Completed	(Specify Elamantary/Second	only highest grad	a complated) Collega (1-4c	or 5+)	(Giva lifa. L	NOT	usa ratire	during most d)	or working				
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0	Andrew Jo	onn Chipc	nosky					S1	tella	V. Mu:	zia		
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Medical	that initiated evants rasulting in daath) La	st		Due to (o	r es a conseq	uanca of	):				W		
lan													
Physician/M	Part II. Other significa	ant conditiona cor	ntributing to death	but not res	ulting in the u	ndariying	causa giv	an in Part I.			obacco usa co 'ea 2 No		the cause of death pably 4 Unknown
Completed by										24a. Was e		ava	are eutopsy findings allabla prior to applation of cause daath?
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To	exeminer? 1 ☐ Yas 2 ☐XNo	) H	lospital:	itiant 2	ER/Outpatien	t 3 🗆 [	OOA Oth	or:			enca 6 □Oth	nar (Specif)	1)
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Certification:	3 ☐ Suicida 4 ☐ Homlcida	6 Could not be datarminad	28a. Placa of building,	injury - At ho atc. (Spacif	oma, farm, str	eet, facto	ory, office		281	Location (S City or Tow		ber or Rura	l Routa Number,
edicai		Certifying Phys Madical Exami		of axamina									
Medical Certificatio	29b. Signetura and titl		Cr	_ ~		2	9c. Licans				9d. Deta signe		
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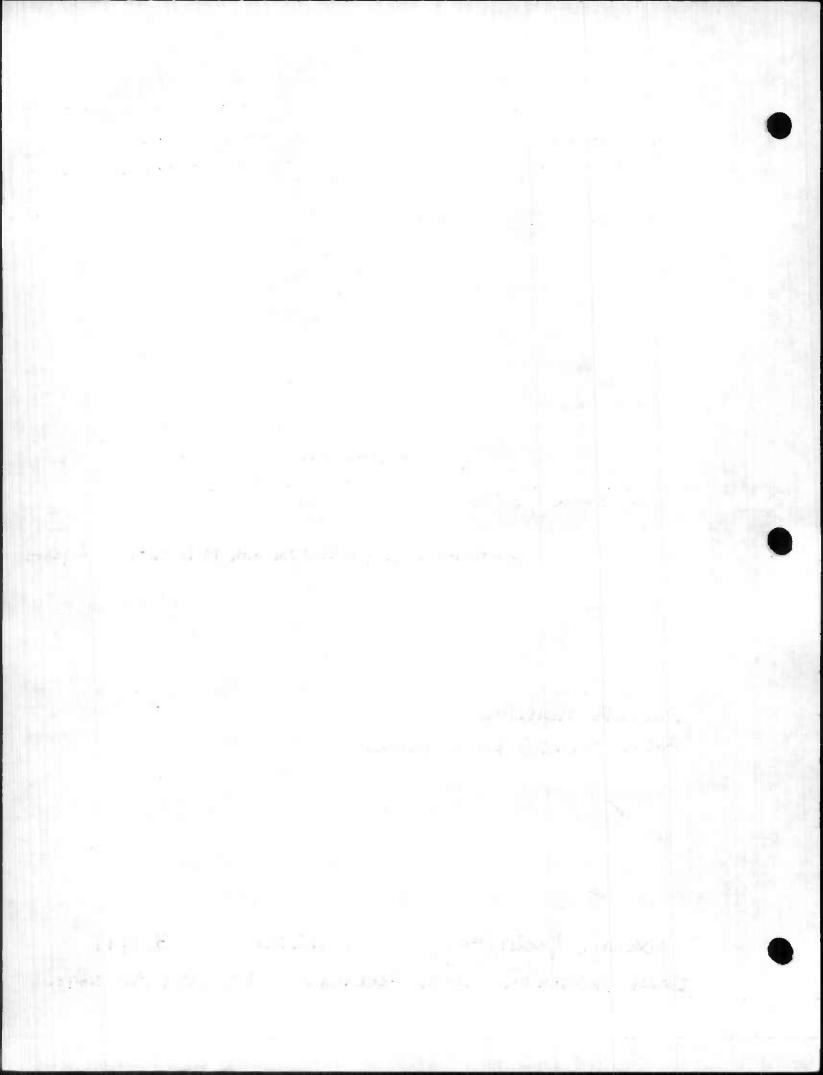
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hydiene

	1. Decedent's Na	me (First, Middla,	Last)		001	imoato or	Death	2. Data of Dec		,	3. Tima of Death	
Physician	Cather	rine T. C	Colucci					Month March 3	, 1999	Year	10:30 AM	
/Medical Examiner	4a Facility Nama	(If not institution, g	give street and nu	mber)			4b. City, Town, or Lo			of Death		
	1806 F1	orin Stre	eet				Silver Spr	ing	Montge	omery		
neral ector	5. Social Security 579-48-		Sex 111 M 22 F	7. Aga (In yrs. 76	last birthday) Yrs.	If Under 1 Yaar Months Days		8. Date of Birt (Month, Day Apr. 29	h (Year)	9. Birthole Counti	aca (Stata or Foraign ny) ngton, DC	
tor	Usual Rasidenca			70				mpr. 23	, 1722	wasiii	ingcon, bo	
	10a. Stata	10b. County		10c. Cit	ty, Town or Loc	cation				10	d. Inside City Limits	
ctor	MD	Montgor	nery	Sil	ver Spr	ing					1 ☐ Yas 2 ☐ No	
Director	10e. Street and N					10f. Zip Code			10g. Citizen of W	/hat Count	ry?	
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Be Completed by Funeral	- 1 - 1 - 1 - 1 - 1	rriad 2 XMarried	Armed Fo	2 X No		Yas Decement of I Yas, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity res or No- Rican, atc.)	Specify:	k, Whita, a		
ted	/50	15. Decedant's	Education		16a. Deced	ent's Usuel Occup	pation during most of work	ina	16b. Kind of Bu	siness/Indu	ustry	
nple	Elementery/Sec		Collega (		lifa. D	O NOT use retire	d)		1			
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Be C		poraletti						th Gesu		9/		
2	19a, Informant's i	Name/Ralationship	(Type, Print)		19b. Meilin	a Address (Street	t and Number or Run	al Route Numbe	er, City or Town,	Stata, Zip (	Coda)	-
		. Colucci		d			St., Silve					
	20a. Mathod of Di	isposition	N. I. W.	20b. F	Plece of Dispos	sition (Name of latory or other pla		Deta	20c. Location - (		vn, Stata	
		2 ☐ Cramation 3 5 ☐ Othar (Spe		Stara		eaven Ce		/6/99	Silver	Sprin	ng, MD	
	21. Signature of	unerel Sarvice Lic	ensee	,	22.	Name and Addre	ess of Facility Fra	ncis J.	Colling	s Fun	eral	
To Be Complet	1	Kevin	gut	HINK	Si	lver Spi	. 500 Unvi	20901	Blvd.,	West		
	23a: Part1. Enter	the disaasa, or co	omplications thet	caused the daet			ng, such as cardiac	or respiratory ar	rest,	1	Approximate Intervel Between	
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	resulting in death	) Last	d			ience of):	ven in Part I.	23b. Dld 1			the cause of death?	
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month March 8,1999 Raymond Finley Courtney 12:46 PM /Medical 4b. City. Town, or Location of Deeth 4a. Fecility Neme (If not institution, give street end number) 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 20, 1908 If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign 1∰M 2□ F Deys Illinois Yrs 221-01-3406 Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Yes 2 No Director Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8101 Connecticut Ave. 20815 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 to the second of the second 1 ☐ Never Married 2 ☑ Married 1 Yes 2 XNo Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) U.S. Gov't. Department of State 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be Raymond Courtney Florence White 19e. Informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claire Donahue Courtney/wife 8101 Conn. Ave., Chevy Chase, Md. 20815 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory Mar. 10,99 Alex., Va. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility DeVol Funeral Home 2222 Wisconsin Ave., N.W., Washington, DC 20007 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Anterioseleratic Cardiovascular disease Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in death) Lest ardrac Physician/Medical Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of geath? 1 Yss 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Deeth (Check only one) examiner? 1 ✓ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Death 28a. Date of Injury (Month, Dev Yeer) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Injury at Work?
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orgetown Rd. Bethesdu ma

State Registrar

31. Date finds

**Funeral** 

Director

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2 should be filed within and Mantal Hygiena.
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**Physician** 

/Medical

Examiner

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Hospital or Attending Physician:

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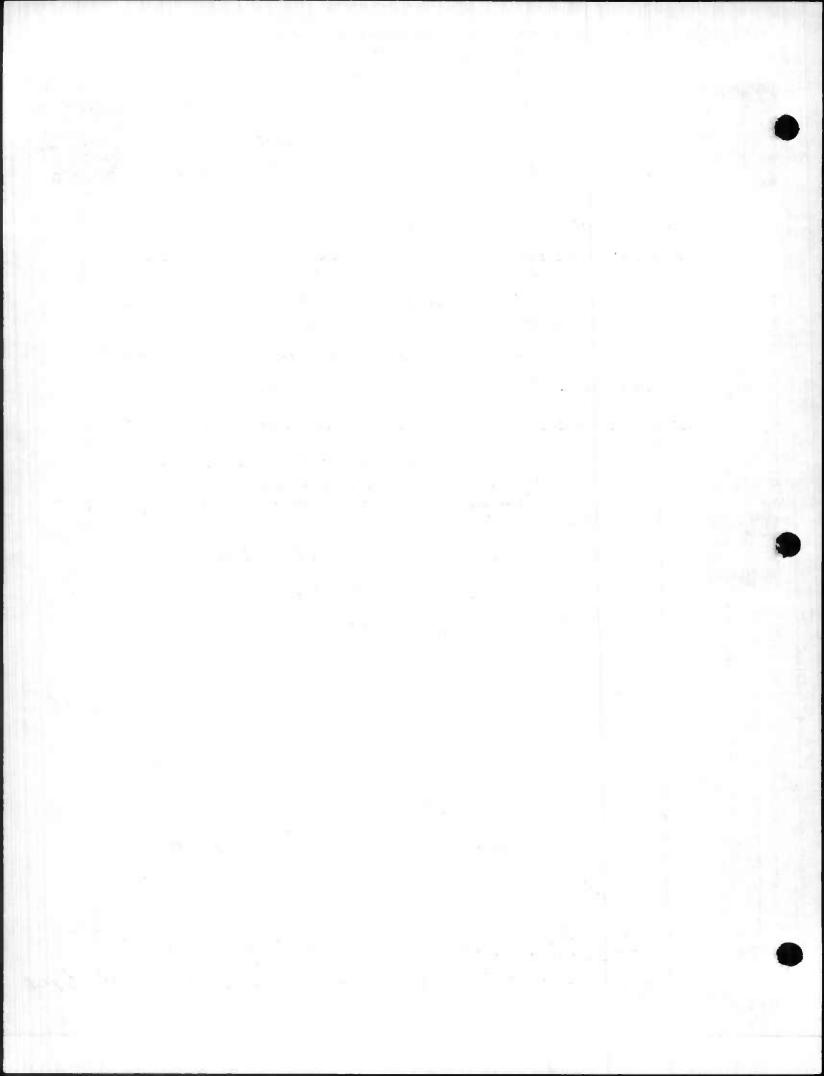
To the Hospital of within 24 hours af To the Funeral D complately filled is

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Laymond

the Maryland

Saltimore, Maryland 21215-0020



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1 Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Deeth Month March 6, **Physician** Estella Cubbage 1999 5:10 a.m. /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys 1□M 25 F 577-24-6446 91 Yrs. April 4, 1907 Maryland Director Usuel Residence of Decedent with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. toside City Limita 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at MD Gaithersburg 1 □Wes 2 □ No Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20877 201 Russell Avenue death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Meritel Stetus Bleck, White, etc. nit. Peges 1 and 2 should be filed within 72 hours efter retrinent of Health and Mentel Hygiene. ortant: If Item 27 is marked other than "natural", or ite injury or other thaumatic event, the Walles Item in Injury or other thaumatic event, the Walles Item in Injury or other thaumatic event, the Walles Item in Injury or other thaumatic event, the Walles Item in Injury or other thaumatic event, the Walles Item in Injury or other thaumatic event, the Walles Item in Injury or other thaumatic event, the Walles Item in Injury or other thaumatic event, the Walles Item in Injury or other thaumatic event, the Walles Item in Injury or other thaumatic event, the Walles Item in Injury or other than Injury 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18 Mother's Name (First Middle Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Clara Olive Hansel James Weir 2 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 18149 Kitchen House Court, Germantown, MD 20874 Freda Thawley Daughter 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Pege Depertment of Important: If any Injury or 3/11/99 Laurel, Maryland Baltimore/Washington 4 Donetlon 5 Other (Specify) Crematory 22. Name and Address of Facility
Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue 21. Signeture of Funerel Service Licansee N.W., Washington, D.C. 20016 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Coronary Artery Disease years **Examiner** Due to (or es e consequence of) Examiner the death certificate be executed the bunel-trensit and Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequenca of): Box 68760, physician Physician/Medical Due to (or es e consequence of): 98 use jo signed by the a 23b. Did tobacco use contribute to the cause of death? P.0. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown by 24b. Were autopsy findings evelleble prior to Completed 24e. Wes en eutopsy peen completion of cause of death? page 2 has 1 TYes 2₺ No 1□Yes 2□No certificete Division of Vital Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certific. funeral director. Be 25. Wes case referred to medical 26. Plece of Death (Check only one) examiner? Other: 41 Nursing Home 5 Residence 8 Other (Specify) o L 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation Injury 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, offica bullding, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) npletely filled in by 4 | Homicide 1 Certifying Phyaician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es stated.

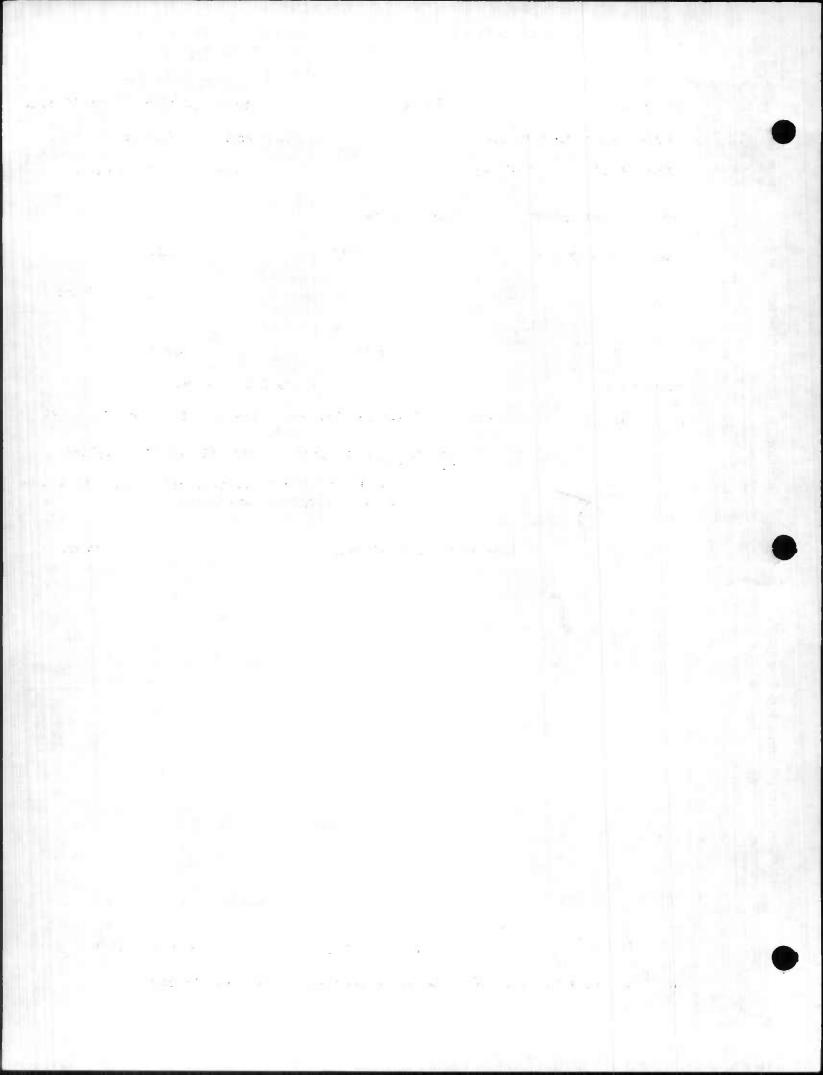
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pieca, and due to the ceuse(s) end menner stated. 29e. Certifier Medical To the Vithin 2 29d. Dete signed (Month, Dey, Year) 29b. Signeture egotitle of certifier 29c. License number D20516 March 8, 1999 2 d eddress of person who completed cause of deeth (Item 23e) (Type, Print) 30. Name a R. Schulman, M.D. 9410 Old Georgetown Road, Bethesda, MD 20814 31. Dete filed (Month, Dey, Year)

State Registrar

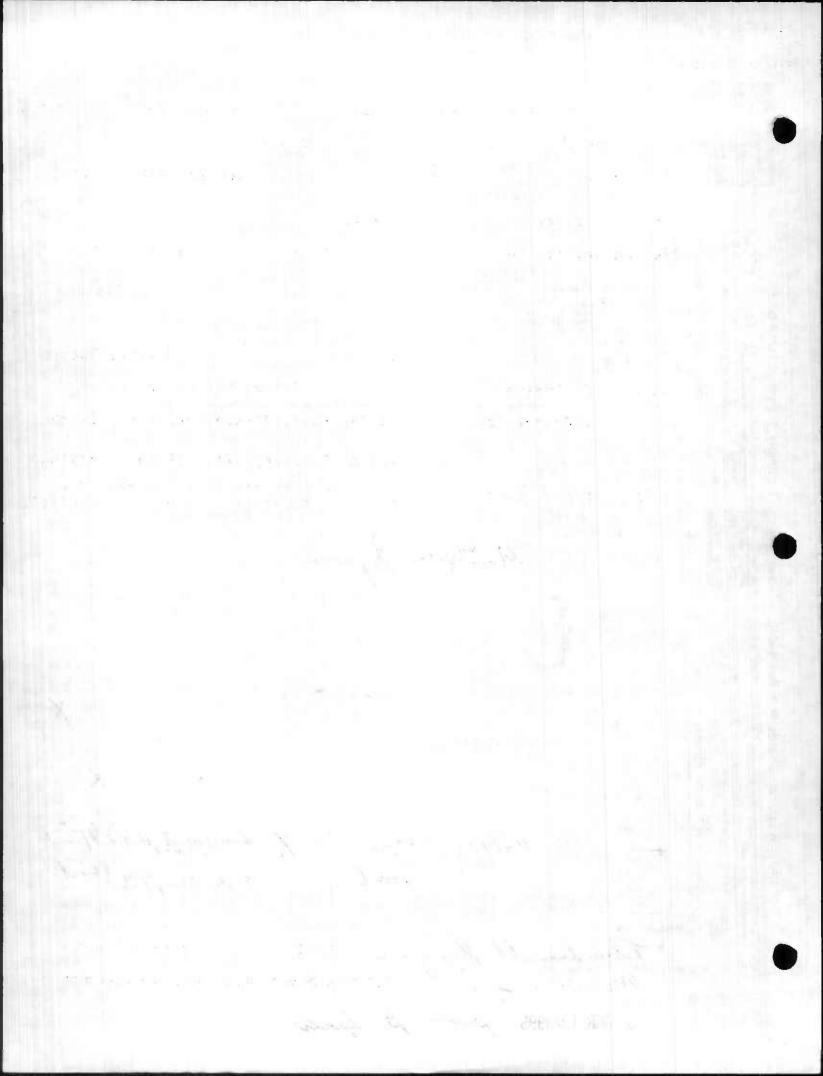
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32. Registrer's Signeture

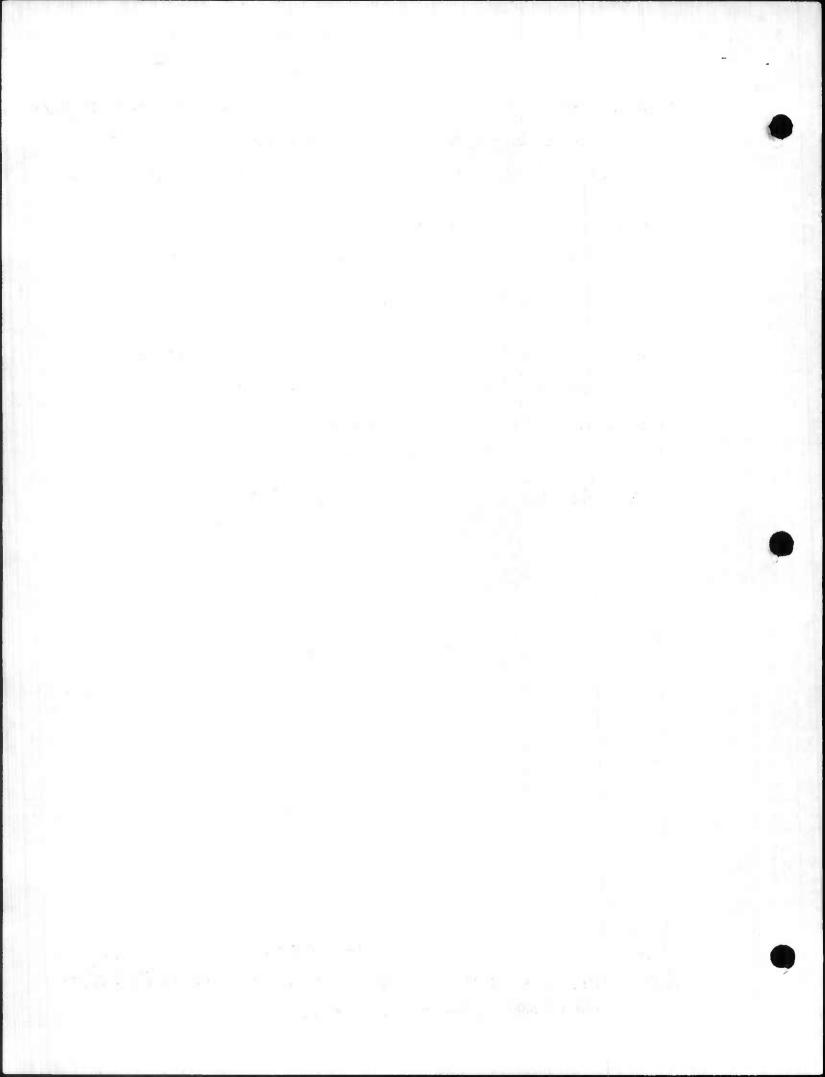
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	per				Certifica	ate of D	eath		Reg. No. 9	0.9	9/27
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by Funeral Director	11. Marital Status  1 Never Marr 3 Widowed	led 2□ Married 4 <b>X</b> Divorced	12. Wes Decedent E Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			V	panic Origin , Mexican, F Specify:	n? (Specify Yes or I Puerto Rican, etc.)	No- 14. Ra Bla Specia	ce - Americ ck, White, fy: B1	
ted	(Sne	15. Decedent's Ed	ucation	16	a. Decedent's Us	sual Occupat	ion	f working	16b. Kind of E	Business/in	dustry
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ation: T	27. Manner of Deat  1  Natural  2  Accident	h 5 Pending investigation	28a. Date of Injury (Month, Day)	28b	Time of lainty	28c. Injury Work?	at V	28d. Describ	e how injury occu		gret third
l Certification:	3 Suicide 4 Homloide	6 ☐ Could not be determined	building, etc.		wood	way		Eastm	(Sheet and Num Town, State)	ay of	treet
edical	29a. Certifier (Check only one)	2 Medical Exam	valcian: To the best of iner: On the basis of a and manner state	examination a	ge, death occurre and/or investigati	on, in my opi	nion, death	occurred at the tim	e, date and place	anner as s , and due to	o the cause(s)
Me	29b. Signature and	title of cartifier				29c. License	number		29d. Dete sign	ed (Month,	Day, Year)
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Physici	ian	1. Decedent's Neme (First, Middle, L	ast)				2. Date of Dea MontMAR	th 90ay 1999	Yeer	3. Time of Death
/Medi		ERNEST A. CRUMP	in atract and aumbor			4b. City, Town, or Lo	JAN	09 1		1:05 AM
Examir	ner	4e. Fecility Neme (If not institution, g NATIONAL NAVAL MI				BETHESDA		4c. County MONTG		
<b>.</b>				s. last birthday)	f Under 1 Year	If Under 24 Hrs.				o /State or Forni
Funeral Director		228-38-7003 Usuel Residence of Decedent	11XM 2□ F		fonths Deys	Hours Min.	8. Dete of Birth (Month, Day Oct. 6,	1933	Virgin	e (Stete or Forei ) nia
Š ==		10a. Stete 10b. County	10c. (	City, Town or Locati	ion				10d.	Inside City Limi
f show	ō	Delaware Kent	D	over						WXYes 2□
ms 23s or 28s-f show	Funeral Director	10e. Street and Number	Di		10f. Zip Code		1	Og. Citizen of V	Whet Country	?
23a or	ā	423 Collins Driv	΄.		19901			USA		
2 2	Jers	11. Meritei Stetus	12. Was Decedent Ever In	U,S. 13. Wes		lispenic Origin? (Span, Mexican, Puerto	ecity Yes or No-		e - American	Indien,
or its	by Fur	1 Never Married 2 X Merried 3 Widowed 4 Divorced	Armed Forces?  1 X Yes 2 No 1 9  If Yes, Give Yeer or Detes: 1	153	es, specify Cube	sn, Mexican, Puerto  Specify:	Rican, etc.)		ck, White, etc	
natural', ofical Ex	8	15. Decedent's 8		16e. Decedent	t's Usuel Occup	eation		16b. Kind of Bu	usiness/Indus	itry
- 6	Completed	(Specify only highest g	rade completed)	(Give kind	d of work done of NOT use retired	during most of work	ing		3011000111000	,
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Mentel or artic eve	To B	John W. Crump,	Sr.			Ruth L.	McCray			
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oth ed		20e. Method of Disposition	20b	Plece of Disposition	on (Name of			20c. Location -		, Stete
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Medical xaminer	niner	Immediate Cause (Final disease or condition resulting in death)	e. BRONCHOALU Due to	(or as e consequer	Table 7 I I	ER: SEPSI	SPNEUMO	COCCAL		
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certificate rector, pa	Be	25. Wes case referred to medical examiner?	Hospitei:		000	26. Plece of Deetl	h (Check only on	10)		
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500	Certifi	3 ☐ Sulcide 6 ☐ Could not lead to determined		home, term, street, :ify)	factory, office		28f. Location (Si City or Town	treet and Numb n, Stete)	er or Rural R	oute Number,
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State Registrar

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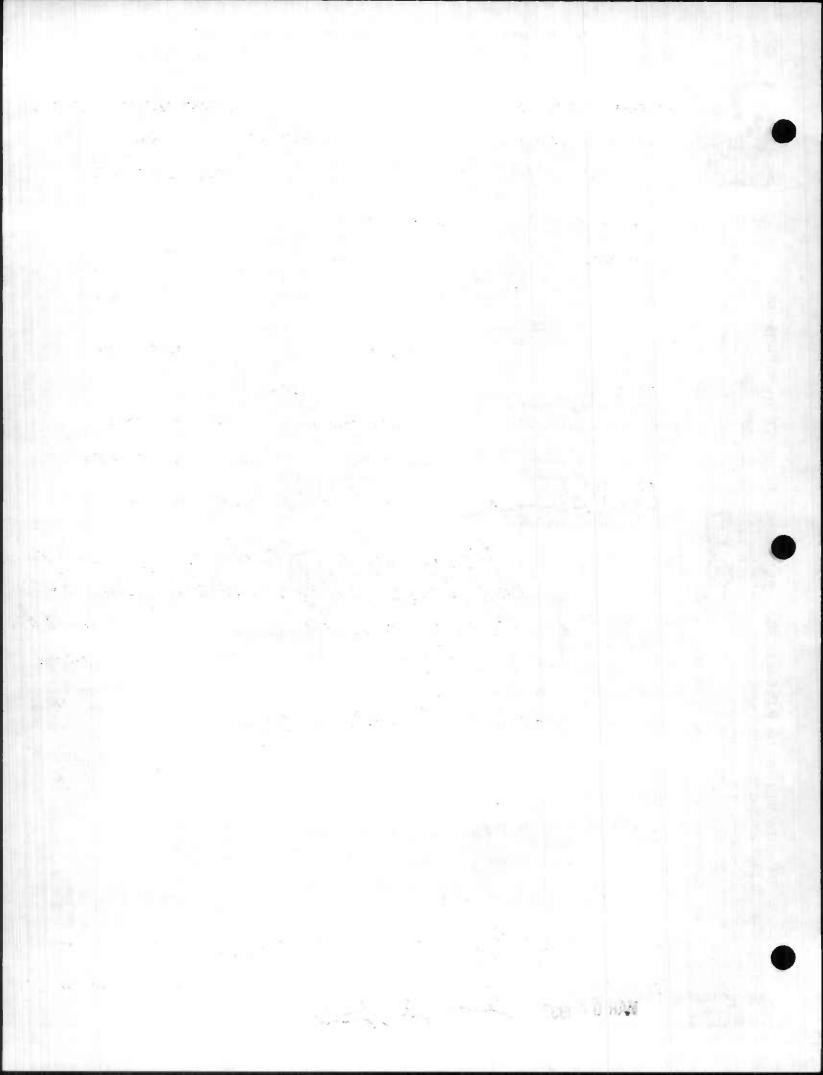
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SANDHIK

altimore,

Box 68760,

Division of Vital Records,



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death Day CATHERINE LEE COVELL March 9. 1999 1520 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Northampton Manor Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Frederick Frederick Birthplace (State or Foreign Country) 6. Sax 7. Age (In yrs. lest birthday) 10 M 20 F Months Yrs. 220-18-1833 88 Dec. 9, 1910 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Frederick Frederick 10e. Street and Number Montevue Nursing Center 10g. Citizen of What Country? 10f. Zip Code 355 Montevue Lane 21701 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Giva Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Maritai Status Black, White, atc. 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: 3 Nidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Irving Cleveland Preston Beard Mamie Lavenia Burrier 19a. Informant's Name/Relationship (Type, Pnint) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly C. Damuth (Daughter) 125 Buttercup Drive, Hagerstown, Maryland 21740 20a. Method of Disposition 149 Burial 2 Cramation 3 Removal from State 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date Mount Olivet Cemetery 3/12/99 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Addrass of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET FREDERICK, MD. 21701 Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EXTENSIVE COREBROURSCHUR ACCIDENT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown URWARDY TRACT INFECTION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ACUTE BLADDER OBSTRUCTION 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

**Physician** /Medical **Examiner** 

the death certificate be axecuted

Box 68760,

P.O.

Division of Vital Records,

Physician:

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after death.

24 hours a Funeral C Hospital

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**Physician** 

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**Funeral** 

**Director** 

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Menleth Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the wastest Examine mail to notified as

3altimore, Maryland 21215-0020

Examiner physician and the bunal-trans Physician/Medicai USB BS I Po ed by the a signed t P Completed page 2 s hes certificate Be Certification: To Aftar this uneral

25. Was case referred to medical examiner? 1 Yes 20 No 27. Manner of Deeth Natural 5 Pending investigation

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 28b. Time of

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

1 TYes 2 □ No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 - Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piace, end due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of actifier.

32171

29d. Date signed (Month, Day, Year) March 10, 1999

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

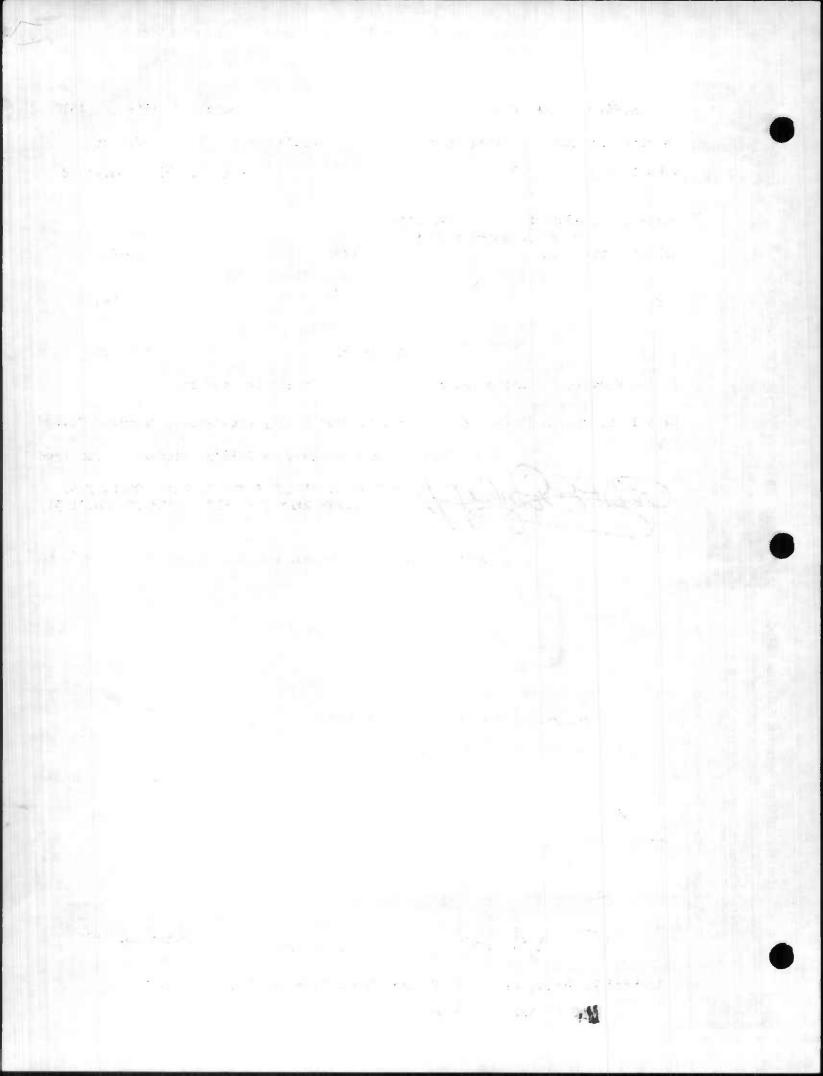
Richard L. Gough, MD 31. Date filed (Month, Day, Yeer)

6 Could not be determined

19 Frederick St. Walkersville, Md.

State Registrar

32. Registrens Signature AR 1

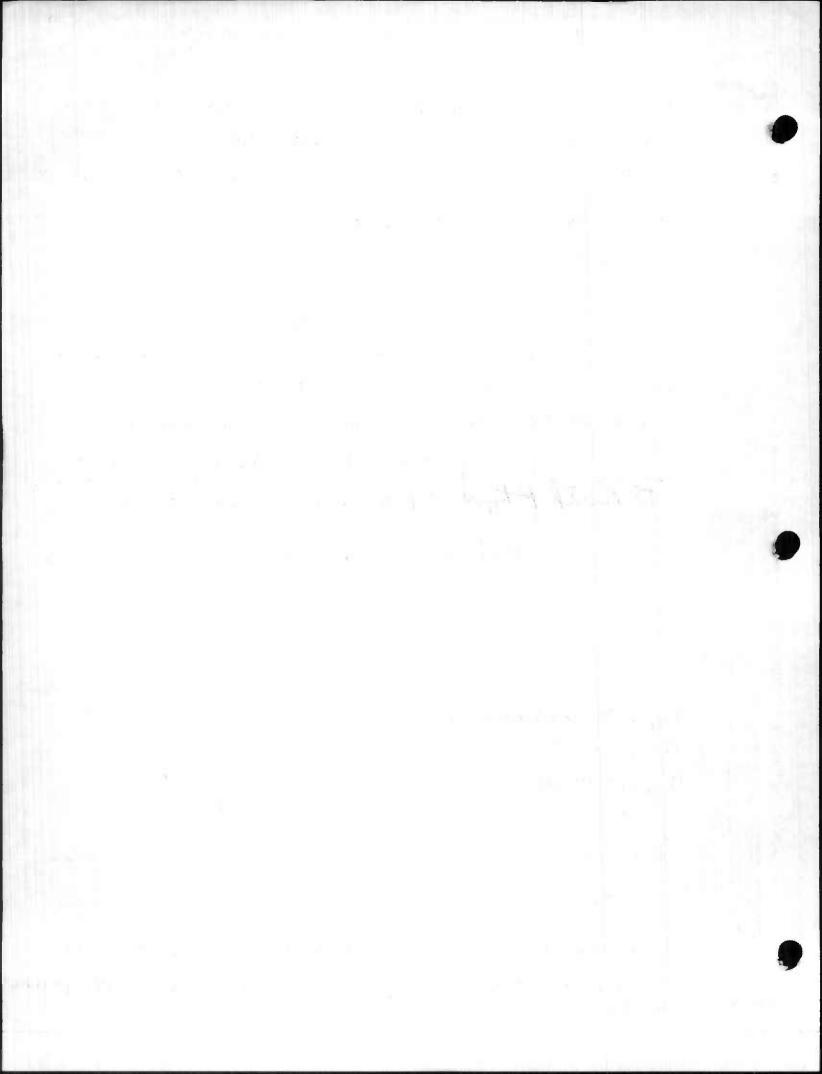


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Physician /Medical EMERSON

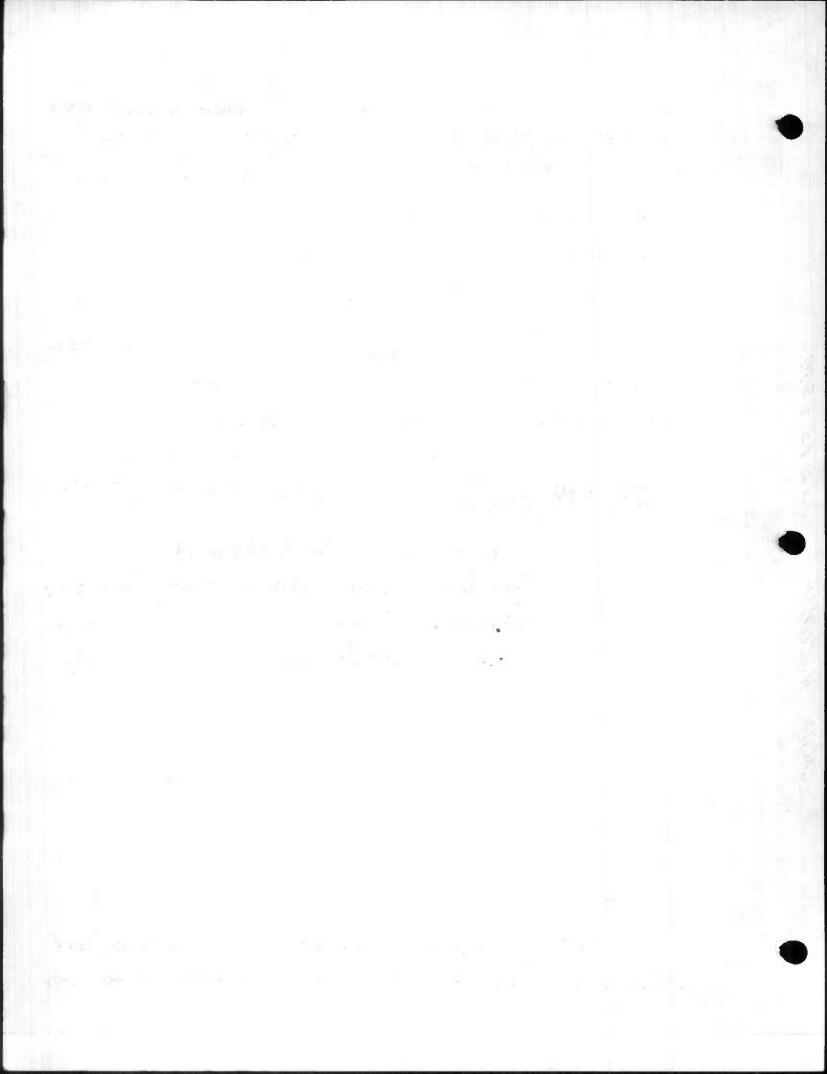
Exa	mine	r	4a. Facility Nama (I	f not institution	n, giva street and n	num <i>ber)</i>				4b. City,	Town, or L	ocation of Dea	th 4c. Count	ty of Death	
			7842 CROF	TON DR						PAR	SONSB	URG	WI	COMICO	
Fune Direc	_	- 1	5. Sociel Security N 215-26-50		6. Sax 1 ☑ M 2 ☐ F		67 Yr		if Undar 1 Yas Months Day		ler 24 Hrs. s Min.	8. Data of B (Month, D	irth Pay, Yaar) 7,1932		a (State or Foreign ) JERSEY
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month 03/4 WALTER CLIFTON MARCH /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 5 Social Sacurity Number If Undar 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funerai** 158 M 2□ F Deys Hours 77 Yrs. 222-05-4577 Director October 26,1921 Delaware Usual Residence of Decedent tha Marylend 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show Maryland Wicomico Salisbury Director 1 ☐ Yes 217 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30592 Zion Road 21804 USA Funeral 12. Wes Decedant Evar In U,S. Armed Forces? 1 ☑ Yas 2 ☐ No Navy If Yes, Give 11. Marital Status Was Decedent of Hispenic Orlgin? (Specify Yas or No If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Rece - Amarican Indien, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Be Completed by Specify White 3 Widowed 4 Divorced WW II The Medical 16a. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Spacify only highest greda completed) Pegas 1 and 2 should be filed within inent of Haalth end Mantai Hygiene. Int: if item 27 is marked other than "ray or other traumatic event, ine Mag Elementary/Secondary (0-12) College (1-4or 5+) AC & Refrigeration 9 Engineer 17. Fether's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surname) William Walter Clifton Emma Mary Torbert 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dollie Clifton/Wife 30592 Zion Rd., Salisbury, MD 21804 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriei 2 ☐ Cremation 3 ☐ Removal from State Department of important: if any injury or 3/5/99 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Hurlock, MD 21. Signeture - Funeral Service Licensee 22. Name end Address of Facility M01051 Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Pentl. Enter the disease, or complications that caused the deeth. Do not anter tha mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Onset end Deeth **Physician** arror due to Ventriul /Medical Immediate Ceuse (Final disease or condition resulting In deeth) Examiner Wastrom Pala The lew requires that the death certificete be executed for usa es tha burial-tren Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated avents resulting in deeth) Lest Due to (or as a consequence of): ITLDIV Physician/Medical Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 4 Unknown 1 ☐ Yaa 2 ☐ No 3 Probably Vital Records, þ 9 page 2 should Completed 24a. Wes en eutopsy performed? Were eutopsy findings aveileble prior to complation of cause of deeth? cartificate hes 2 No 1 Yee 2 No Physician: 25. Wes cese referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) £ 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of this the funaral 27. Manner of Death Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred of or Attending Pastar death. After Division 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funeral Di 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred et the time, dete and place, and due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) end manner statad. Medical completaly (Check only 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Dey, Year) 15192 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) SHOVE Dr. SALISBURY, MD 21804 , M.D BIBB EASTERN Joseph Badros 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State 5 1999 Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 03 1999 Pauline Emma Cantwell 06 5:55 AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death 921 Brown Street Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 1□ M 2 F Months Days Hours 72 Yrs. 218-20-9543 12/21/1926 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 □ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 921 Brown Street 21804 USA 12. Was Decadant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, atc.) Race - American Indian, Black, Whita, atc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Spacify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 Homemaker Domestic 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) George Elmer Staton Florence May Banks 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mr. William Cantwell, Jr. (son) 921 Brown St., Salisbury, MD 21804 20b. Place of Disposition (Name of comatery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 120 Burlal 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 3/10/99 Salisbury, Maryland Wicomico Memorial Park 21. Signature of Fundral Service Licensee 22. Name and Address of Facility M01051 Holloway Funeral Home P.A. 501 Snow Hill Road, Salisbury, MD 21804 The disease, or complications that used the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Intervel Between Onsat and Death Immediate Cause (Final 6 months Glioblastoma diseese or condition resulting in death) Due to (or as a consequence of) Sequantially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of) Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yae 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 TYes 2 No. 26. Place of Deeth (Check only one) Othar: 4 Nursing Home 5 Assidance 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicida

physician and the buriel-tran P.O. Box 68760. esn ò the the detech signed by Division of Vital Records. peen hes certificete I or Attending Physician: efter deeth. Director: After this certifice director, funeral

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**Examiner** 

Examiner

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7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Marical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Depertment of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or item any Injury or other traumant.

Baltimore, Maryland 21215-0020

with the Meryland

deeth

25. Was cese referred to medicel axaminer?

4 Homicide

29a. Certifier

6 Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of confiner

E280E

29d. Date signed (Month, Day, Year) 9

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 100 mws

3. Silvia Jr Charles 31. Date filed (Month, Day, Year)

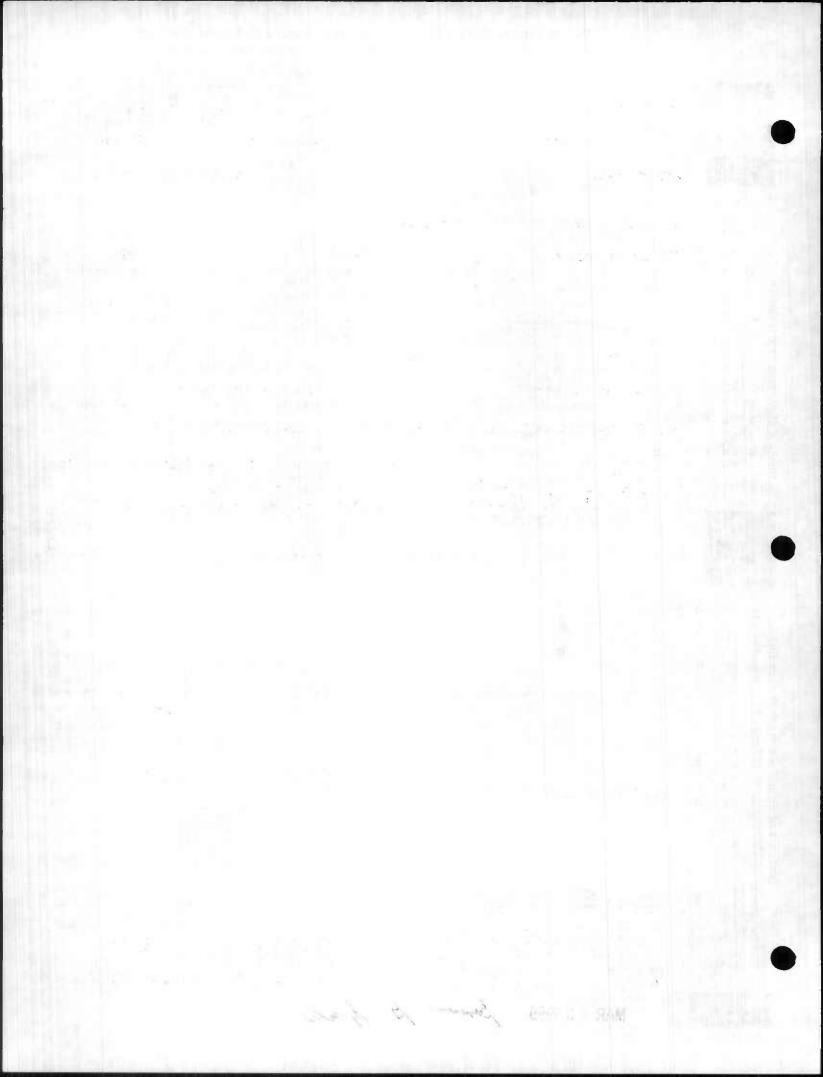
Power Street Salisbury

State Registrar

MAR 0 9 1999

32. Registrar's Signeture

To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by the



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				State	OI WILL		epartment of Certificate of			Reg. No.	UB	1134
	Diam'r.		1. Decedent's Nama (First, Mic	idla, Last)					2. Deta of De Month	ath	Vaar	3. Tima of Death
	Physici /Medic		ROBERT ED	WARD	CROSS				Februar	y 22, 1	999	6:20 PM
	Examir		4a. Facility Name (If not Institut					4b. City, Town, or		,		
			Washington Co					Hagerstov			ingtor	
	Funeral Director	8	5. Social Security Number 220-94-2274	6. Sex 1 M 2 □ F		In yrs. last birthd Yrs	Months Days			h y, Year) ', 1964		aca <i>(Stata or Forei</i> gn ry) Jersey
	nyland show		Usuai Rasidance of Decedant  10a. Steta 10b. Cour	nty	1	Oc. City, Town o	r Location				10	Od. Insida City Limits
	Ba-f	Director	MD Ga	rrett		Swa	nton					1 □ Yas 2 🔯 No
	or th	Dire	10e. Street and Number				10f. Zip Code			10g. Citizan of \	What Count	ry?
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020	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hyglena. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examine must be notified at	by Funeral	11. Meritel Stetus  1 ☑ Navar Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorc	arriad 1 ☐ Ya If Yas,	ecedent Eve Forces? is 2 \( \) No Giva r Dates:	er In U,S. 1	<ol> <li>Was Decedant of If Yes, specify Cult</li> <li>1 ☐ Yas 2 ☑ No</li> </ol>		Specify Yas or No to Rican, atc.)	Specify	a - America ck, Whita, a	
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lan	2 should and Men ie marke aumatic		19a. Informant's Name/Ralatio	nship (Type, Print)		19b. M	ailing Address (Stree	and Number or Ri	ural Route Numb	er, City or Town,	State, Zip	Coda)
	1 and 2 Heelth em 27 i		Jay N. Cross/	Father		154	4 Turkey	Neck Road	i, Swant	on, MD	21561	
altimore,	00		20a. Mathod of Disposition 1 ☐ Burial 2 ☑ Cremetion 4 ☐ Donetion 5 ☐ Othar			camatary,	sposition (Nama of crematory or other place Crematory)		3/3/99	20c. Location -		
Balt	permit. Pag Department Important: Il any Injury o		21. Signatura of Funaral Service	o Lipengee			22. Name and Addr Stewart F	ess of Fecility Uneral Ho	ome			
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387	icate phys s the	edicai	that initiated events resulting in death) Last		Du	a to (or as e cons	sequance of):				į	
×	nding use a			d							1	
Box	attending for use as	Physician/M							1			
P.0.	the d	ıysi	Part II. Other significant condi	tions contributing to	death but n	ot rasulting in th	a undarlying causa g	iven in Part I.				the cause of death?
	as that the de igned by the a be detached i		Mental Ret	ardation					10	Y88 20 No	3∐ Prob	ebly 4 ☐ Unknown
of Vital Records,	been should	Completed by								an autopsy med?	con	ra autopsy findings ileble prior to appletion of cause leath?
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<b>\( \)</b>	Physician: this certific ral director,	TOB	axaminar? 1XWes 2□ No	Hospital:	☐ Inpatiant	2 K ER/Outpe	tient 3 DOA	har	Home 5 ☐ Rasio		ar (Specify	)
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	f or Attand after death Director:	Certification:	3 ☐ Sulcida 6 ☐ Coul 4 ☐ Homloida data	mined 288. Pla	ica of Injury	- At homa, farm,	straat, factory, office		28f. Location (S City or Tox	Straat and Numb	er or Rural	Routa Number,
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai		al Examiner: On tha		amination end/or	eath occurred at tha t r investigation, in my					
	vithin 2 To the comple	×	29b. Signetura and titla of cartif	iar			29c. Licen	se number		29d. Date signe	d (Month, D	Day, Year)
			Edwa	ew. S	ikh	200	D010	062	F	ebruary	24,	1999
	4		30. Nama and address of person Edward W. Ditt	n who complated ca	use of deet	h (Item 23a) (Typ	De, Print) Washingto	on St. I	Hagersto	wn, MD	2174	40
	Sta	te	31. Data filed (Month, Day, Yea		Registrar's	Signatura	5. Spa					

		Otate	Of Waryie		tificate of	Death		Reg. No.	U	9135
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Examiner	4e Fecility Neme (If not insti			D ( D ) D (		4b. City, Town, or L	ocation of Deeth	4c. County	of Death	
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Funeral Director	5. Social Security Number 374–36–2943	6. Sex 1 ☑ M 2 ☐ F		rs. lest birthday) Yrs.	Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 11-13-		9. Birthpl Coun Gern	lece (State or Foreign try) nany
yland wor	Usuel Residenca of Decader 10e. State 10b. Co		10c.	City, Town or Lo	cation				10	0d. Inside City Limits
the Meryla 28a-1 shor nourse	MD	Garrett		0ak	land					1 ☐ Yes 2 🔀 No
or 28	10e. Street end Number				10f. Zip Code			10g. Citizen of W	/het Coun	try?
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and Mental Hygiene.  is marked other than "natural", or items 23s or 28s-1 show raumatic event, the Medical Examinet must be notified at To Be Completed by Funeral Director	11. Meritel Stetus  1 □ Never Married 2 ☑  3 □ Widowed 4 □ Divo	Married 1 X Yes	ecedent Ever in Forces? s 2 No Give Dates: Ko	H	Vas Decedent of F Yes, specify Cub  ☐ Yes 2 ☐ No	dispanto Origin? (Sp an, Mexican, Puerto Specify:	ecry Yes or No- Pican, etc.)		k, White,	an Indian, etc. nite
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tam 27 is marked other other traumatic event, To Be C	Herbert		Capelle			Bertha				
marks umatic	19a. Informent's Name/Rela		capelle		g Address (Street	and Number or Ru	rel Route Numbe		Rose State, Zip	Code)
27 is r tra	Erika Capell	e/ Spouse		1250	Pergin	Farms Ro	ad. Oaki	land, MD	215	50
r oth	20e. Method of Disposition	in 2 DRamousline		Place of Dispos	sition (Neme of netory or other pla		Dete	20c. Location -		
ury or	1 ☐ Burial 2 ☑ Creme 4 ☐ Donetion 5 ☐ Othe		m Stete	Omega	Cremator	y	3/9/99	Morgan	town,	, WV
Important: If itam 27 is any injury or other tra once.	21. Signature of Funeral Ser	vice Licensee  A. Marco	<b>b</b>	1		ess of Fecility Funeral H cond St.,		d, MD 21	550	
	23a. Pert1. Enter the disees shock, or heert failure.	e, or complications the List only one cause on	t caused the den	eth. Do not ente	er the mode of dyl	ng, such es cerdiac	or respiretory er	rrest,		Approximate Interval Between Onset and Deeth
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ther no	27. Manner of Deeth 1 Neturel 5 □ Pe		te of Injury onth, Day Year)	28b. Time of Injury		ryat rk? IYes 2 □ No	28d. Describe I	how injury occurr	ed	
y tha	3 ☐ Suicide 6 ☐ C	vestigation ould not be	ce of Injury - A	home farm str	eet, factory, office	163 2 100	28f. Location (5	Street and Numb	er or Rura	I Route Number.
al Director: After to led in by the funeral Certification:	4 ☐ Homicide de	termined 206. Flo	Iding, etc. (Spe	cify)	set, factory, office		City or Tov	vn, State)		
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State Registrar	31. Date filed (Month, Day, )	ear) 32.	Registrer's Sig	4	doors	ab				

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	State of Maryland / Department of Health and Mental Hygiene	9	0	9	3
	Certificate of Death				

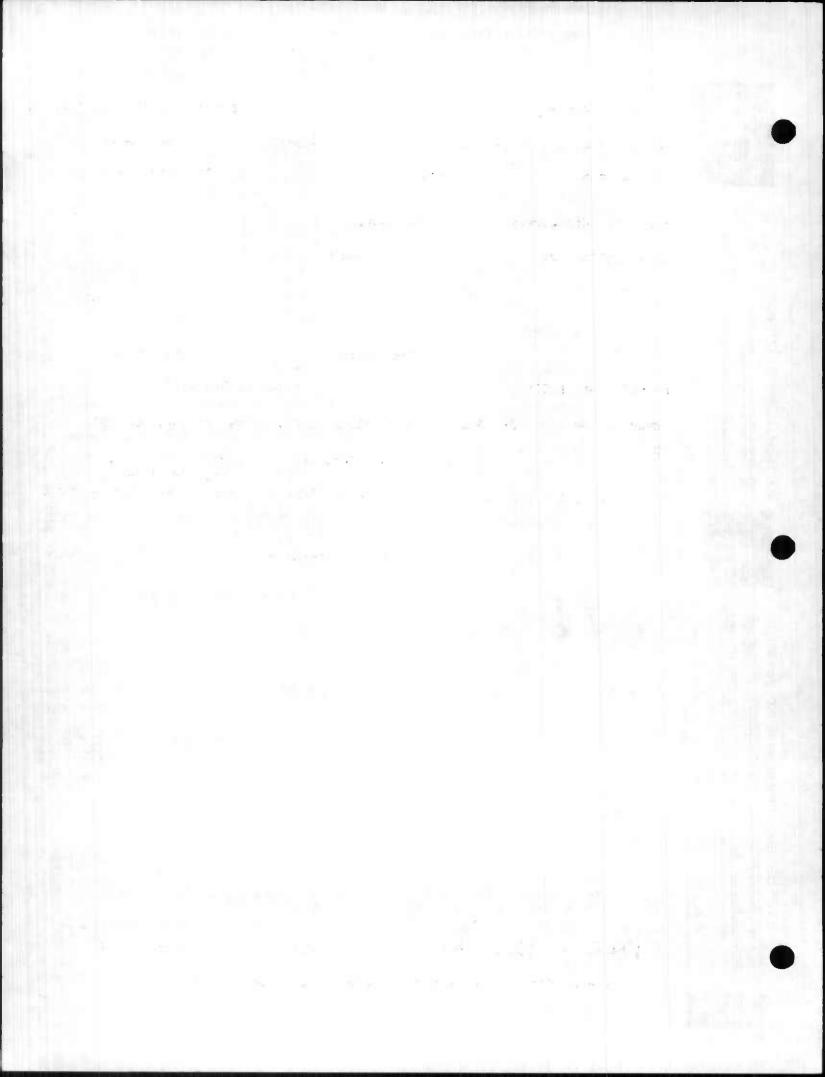
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neral		al Security N		100		s. last birthday,		er 1 Year	If Under 2	24 Hrs.	8. Date of B (Month, D			thplace (State or I
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Completed by Funeral Director	11. Ma 1 🗆 3 🗓		led 2 Married	12. Was Dece Armed Fo 1 Tes If Yes, Giv Year or De	rces? 2 🔯 No /e	U,S. 13.	If Yes, sp	ecify Cuba	lispanic Orig an, Maxican Specily:	gin? (Spe , Puerto	ecity Yes or N Rican, etc.)		4. Race - Ame Bleck, Whit Specify: Wh	a, atc.
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muert men	19a. Ir	nformant's Na	ame/Relationship	(Type, Print)		19b. Mall	ling Addres	ss (Street	and Numbe	r or Rura	I Route Num	ber, City or	Town, State,	Zip Code)
	Gi	la Nor	rdman / d	laughter					Ave.,F	Rock	rille,			
		ethod of Disp		☐Removal from		Place of Disp cemetery, cre	osition (Na matory or	ame of other plac	ce)		Date	20c. Loc	ation - City or	Town, State
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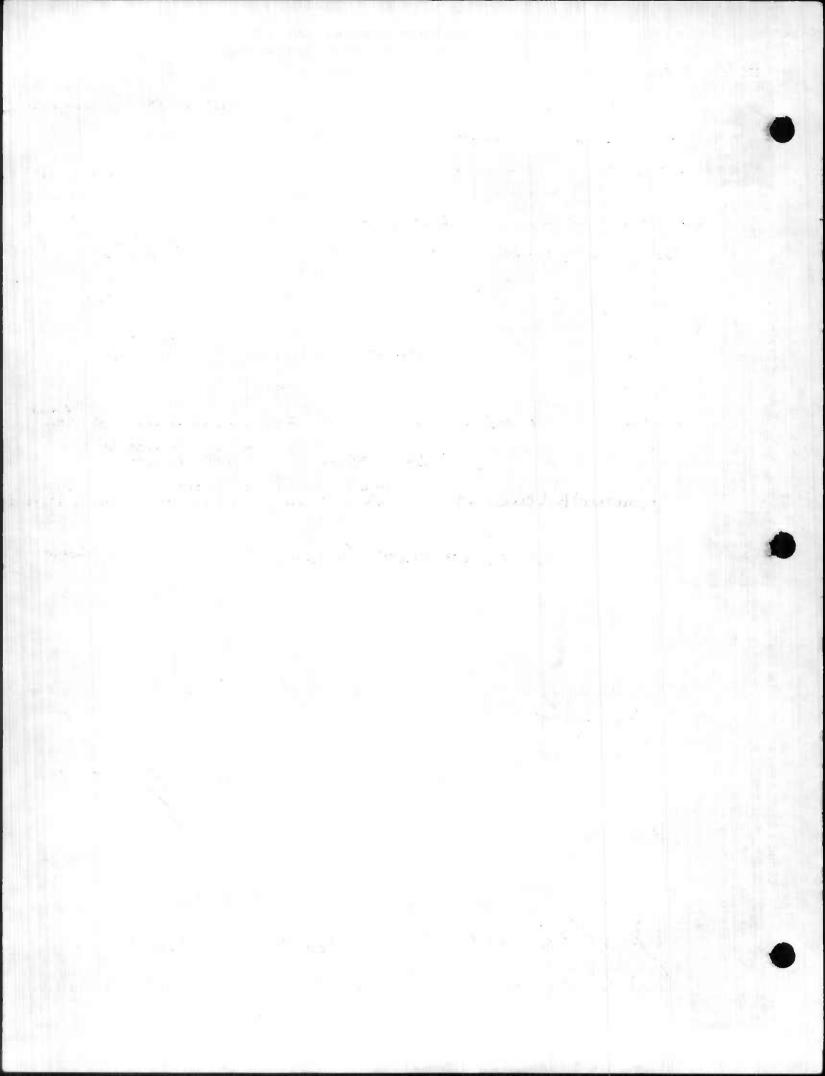
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State of Maryland / Department of Health and Mental Hygiene 9

	1. Decedent's N	leme (First, Middle, La	st)			,,,,,,,,		Death	2. Date of De			3. Time of Deat
hysician	Louise	e E. Devone	ev						Month	4, 1999	Yeer	1:40 P
/Medical Examiner		e (If not institution, giv		er)				4b. City, Town, or	Location of Deet			
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uneral rector	5. Social Securit	ty Number 6. S 1-2686			last birthday 7 Yrs.	/) If Und Month	ler 1 Yeer s Days		8. Date of Bir	th ev. Year)	9. Birthpl Count	ace (State or For try) York
how i	Usual Residence 10a. State	10b. County	·	10c. Ci	ty, Town or I	ocation.					10	Od. Inside City Lin
5 00	Maryla	and Montgo	omery	S	ilver	Spri	ng					1 Yes 2
or 28	10e. Street end	Number				10f. 2	Zip Code			10g. Citizen of W	het Coun	try?
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rel', or items 23a or 23a-f show Examiner over be norffled at 1 by Funeral Director		us farried 2 Married ad 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? □XNo	J,S. 13		edent of F becify Cub	Hispanic Origin? (S en, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Rece Black Specify:	- America k, White, e	
Important: If item 27 is marked other than "naturel", or any injury or other traumatic event, the Medical Examples.  And the Medical Examples of the Completed by F		15. Decedent's Edipecify only highest greecondary (0-12)	ducation de <i>completed)</i> College (1-4	or 5+)	(Giv life.		vork done use retire	pation during most of wo d)	rking	16b. Kind of Bu	sin <b>ess/i</b> nd	lustry
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E	19a. Informant's	s Name/Relationship (	Type, Print)		19b. Ma	ling Addre	ss (Street	and Number or R	ural Route Numb	er, City or Town,	Stete, Zip	Code)
127 i	Edward	d J. Devone	ey, Jr./S	Son	150	)9 Hi	ghlar	nd Dr, Si	llver Sp	ring, MD	2091	10
oth	20a. Method of				Place of Disposerry, cr	osition (A	leme of	ice)	Date	20c. Location -	City or To	wn, State
7 0 7		2 ☐ Cremetion 3 ☐ on 5 ☐ Other (Specification)		ate e	. Jose				Mar 11	Yonke	rs. N	1Y
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sician edical	23a. Part1. Ent shock, or l	er the disease or combean failure. List only	plications that cau one cause on eac	sed the dee h line.					c or respiratory e	errest,	1	Approximate Interval Between Onset and Death
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ed by the attendin detached for use / Physician/N	Part II. Other sig	gnificent conditions o	ontributing to deat	h but not res	sutting in the	underlying	g cause gr	ven in Part I.		tobacco use con		
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is certificate has director, pege 2 To Be Comp	25. Was case re	eferred to medical						26. Place of De	ath (Check only	one)		
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this ald	2 ☐ Accider 3 ☐ Suicide	6 ☐ Could not be determined	building	est of my kno	owledge, dea etion and/or	ith occurre	ed at the ti	me, dete end plec opinion, death occ	e, and due to the urred at the time,	ceuse(s) and me , date and place, e	nner as st and due to	ated. the cause(s)
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al er	4a Facility Name (If n	not institution,					4b. City, Tox	wn, or Lo	cation of Deeth			
	Manorcare	Heal	th Servi	ces-Pot	omac		Potoma	ac		Montg	omery	County
	5. Sociel Security Num 082-03-830		6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs 82	s. last birthday) Yrs.	If Under 1 Year Months Day		Min.	8. Date of Birt (Month, Da April -1	h y, Year) <b>8,</b> 8 1916	9. Birthp Cour Mas	olace (State or Fo ntry) sachuset
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Funeral Director	10e. Street and Numb	Montgo	mery		Chevy Ch	10f. Zip Code				10a. Citizen of	Whet Cour	ntrv?
ā	5500 Frien		Bouleva	rd		20815				United of Ame	State	es
ŀ	11. Marital Status		12. Was Dec	cedent Ever in	U,S. 13. V	Vas Decedent of Yes, specify Cu		gin? (Spe	ecify Yes or No		ce - Americ	can Indien,
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	Deborah J.			ghter								
20a.	20a. Method of Dispos	sition		20b Place of Disposition (Name of					Date arch	20c. Location	- City or To	own, State
	1 Burial 2 0 4 Donation 5			emoval from State  200. Placa of Disposition (value of cemerical, crematory or other place)  Eternal Light  Memorial Gardens					, 1999	Boynto Florid		ach,
	21. Signa re of Fune				22.	Name and Add	ress of Facilit	у	1 01			3348
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alcal	Immediate Cause (Findisease or condition	litions, lediate ying jury	complications thet only one cause on a	Due to	ath. Do not ente	uence of):	low	cardiac o	AVEITUE or respiratory as	rrest,	ly Bea	Approximata Interval Betwee
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Norman V. Dufault March 9, 1999 12:30 a.m. /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Bethesda Montgomery Suburban Hospital tf Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplece (State or Foreign Country) 1908 New Hampshire 5. Sociel Security Number 7. Age (In yrs. lest birthdey) If Under 1 Year 9. Birthplece (Stete or Foreign **Funeral** 1**⊋**M 2□ F 002-14-5596 Vrs Director 91 Usuei Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits Silver Spring Director MD 1 XYes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examinar must be a 10000 Brunswick Avenue 20910 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American indlen, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried I ☐ Yes 2 ☑No If Yes, Give Year or Dates: White 1 Yes 2 XNo Specify: ð 3 □ Widowed 4 □ Divorcad Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Owner Laundry 8 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) and Mental Pe Vertune Dufault Alma Jette 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 and Opportment of Health a Laboratura of Health a Laboraturit. If Hem 27 is any injury or other traconce. Lorraine Shaughnessy/Daughter 1702 Mark Lane, Rockville, MD 20852 20b. Pieca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/17/99 Ft. Lauderdale, FL Forest Lawn Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue N.W., Washington, D.C. 20016 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner physician and the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t d be datach 1 Yee 2 No 3 Probably Unknown þ 24a. Wes en eutopsy performed? 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? Completed 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) 20 No Hospitel: Other: 4 Nursing Home 5 Residenca 8 Other (Specify) P 1 Yes 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation Neturai death. 1 ☐ Yes 2 ☐ No or Attend after death Director: / 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end pleca, end due to the ceuse(s) end manner steted. 29a. Cartifier Medical 29b. Signature and little of certifies 29c. License number 29d. Date signed (Month, Dey, Year) 11129 BOCKVILLE DILLE 30. Name and address of pers e of death (Item 23e) (Type, Print) POWILLE, MO

State Registrar a filed (Month, Day, Year)

1

1999

32. Registrar's Signature

Lownon

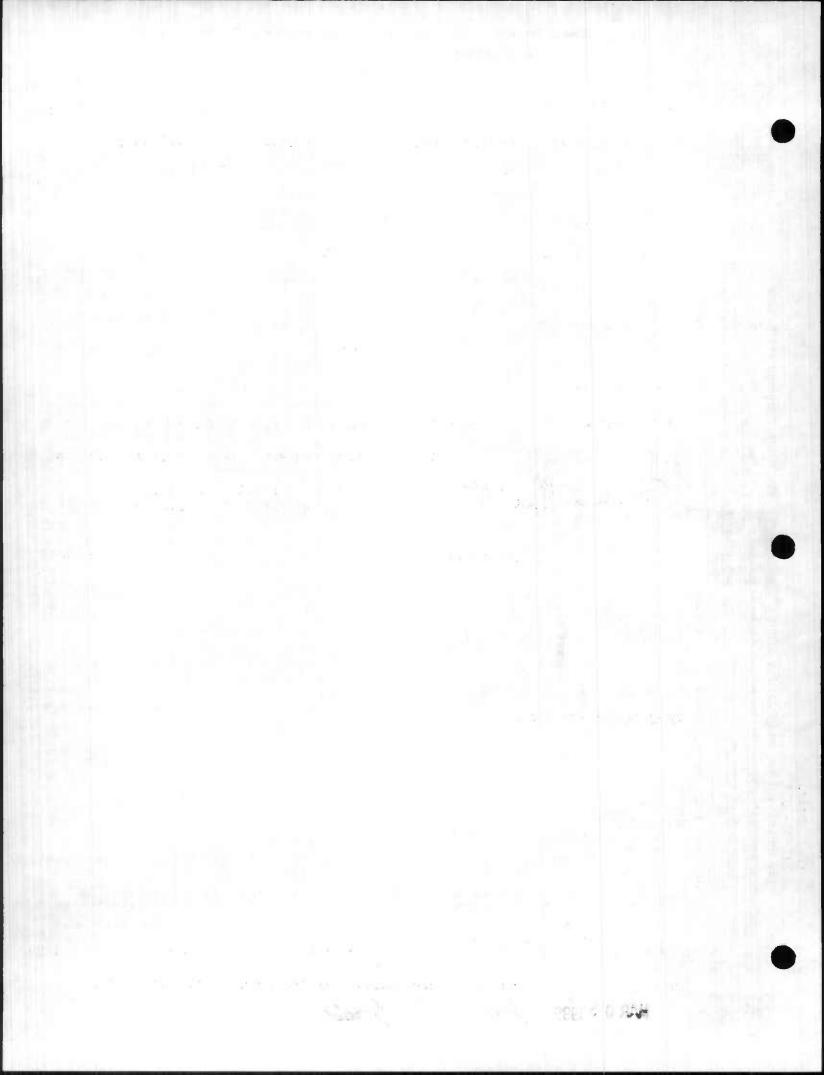
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Month Dey **Physician** FLORA ANNA DOLAN March 3, 1999 7:30 p.m. /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street and number) 4c. County of Deeth **Examiner** Allegany Memorial Hospital & Medical Center Cumberland 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplece (Stete or Foreign 6. Sex **Funeral** Hours Min 1 M 2 TF Months Deys MARYLAND 212-38-6351 99 Yrs. Director Usuel Residence of Decedent 10d. Inside City Limits 10a State 10b Counts 10c. City. Town or Location 1 Yes 2 □ No MARYLAND ALLEGANY Director CUMBERLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ir than "natural", or liams 23a or the Medical Examiner must be 449 BALTIMORE AVENUE 21502 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiene.
Intit If Item 27 is merked other than "natural", or he my or other traumatic event, the Medical Examins 1 Never Merried 2 Married Specify: WHITE Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 Nidowed 4 Divorcad 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) HOUSE WIFE HOUSE WIFE 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be LEE FAZENBAKER ANNA CORNELL 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e, Informant's Name/Reletionship (Type, Print) BETTY SHOBER DAUGHTER 17515 WILLIAMS ROAD S.E. CUMBERLAND MARYLAND 21502 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1X Buriel 2 Cremetion 3 Removel from State Department of Important: If SUNSET CEMETERY MARCH 6 1999 CUMBERLAND MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lio 22. Name end Address of Fecility MERRITT-ADAMS FUNERAL HOME P.A. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

MARYLAND
Approximate Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting In death) 7 WEEKS PNEUMONIA Examiner Due to (or es e consequence of) Examiner physician and the burial-transit that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) 88 use 23b. Did tobacco usa contribute to the cause of death? ed by the detached Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed b CORONARY ARTERY DISEASE by 24b. Were eutopsy findings eveilable prior to Completed 24a. Wes en eutopsy performed? completion of cause of death? page 2 s has certificate 1 Yes 2 No 1 Yes 2 No 212-38-6351 Hospital or Attending Physician: funeral director, 26. Plece of Deeth (Check only one) 25. Wes case referred to medical exeminer? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? 1 Neturel 5 Pending after death. 1 Yes 2 No investigation 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 24 hours a 1⊠ Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated.
2□ Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and menner stated. To the To the To the I 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of control 29c. License number 1999 3 D 33280 March 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) nas Sunil Gupta, M.D., Johnson Heights Medical Building, Cumberland, MD 31. Dete filed (Month, Day, Year)
MAR 0 5 1999 2. Registrer's Signeture State Registrar

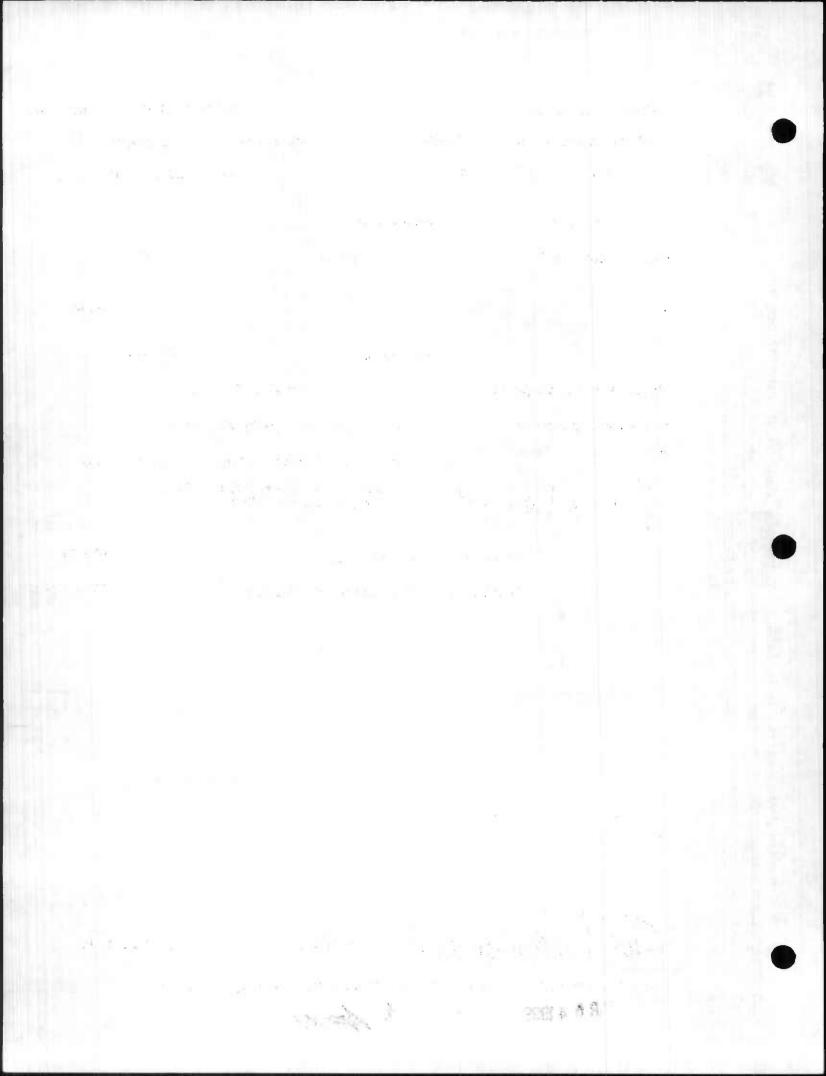
**DHMH 16 Rev 6/95** 

Flora Dolan



State of Maryland / Department of Health and Mental Hygiene 9 9 1 4

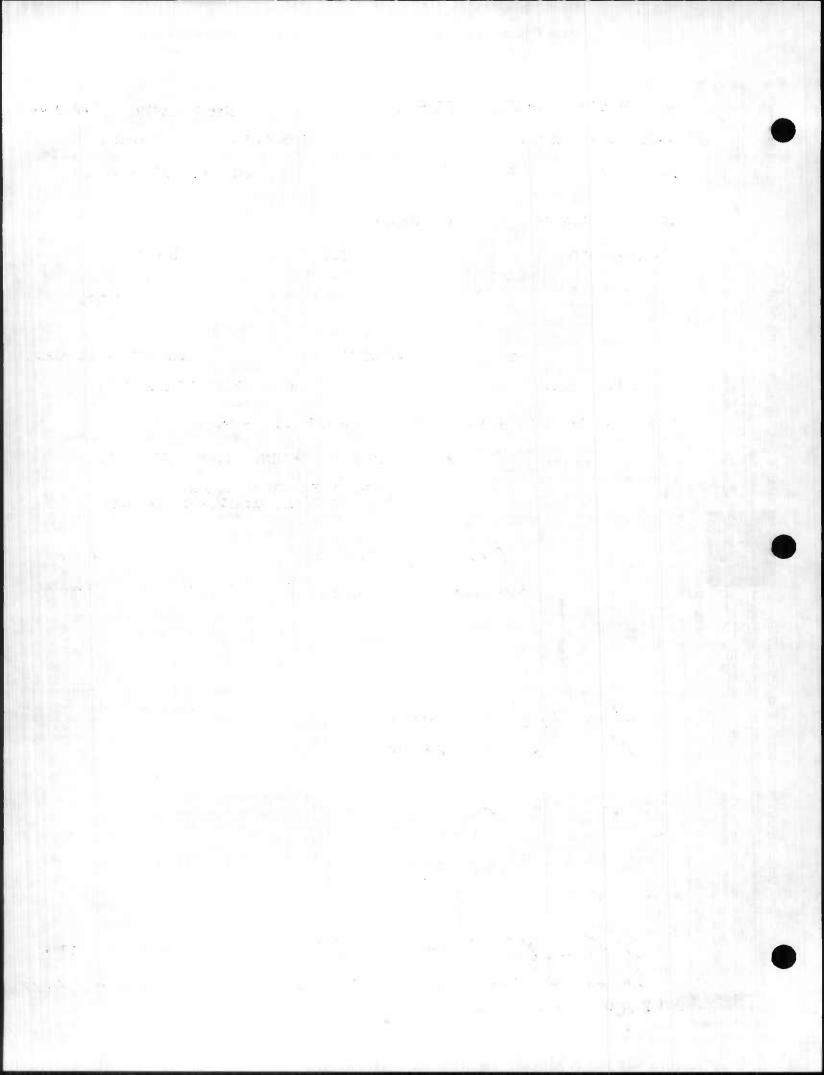
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contribute to the cause of death in the underlying cause given in Pert I.  1   Yes 2   No 3   Probably 4   Unknown in Pert I.  24e. Wes en autopsy performed?  24e. Wes en autopsy performed?  1   Yes 2   No 2   No 2   Yes 2   No 2   No 2   Yes 2   Y							Ce	rtifica	te of	Death			Reg. No.	)	9	r) 1
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Cumberland MD 21502	men		4 Donetion	5 ☐ Other (Speci	fy)	Hi					-	3/04	Cumber	land	MD	
23. Part. Enter the diseases, or Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Appointment individe Between Onset Individe Indivi	Deparit Important any In		21. Signeture of Fr	unerel Servica Lice	nsee	.00	2	Scar	rpel:	li Fune	ral	Home,	P.A.			
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28. Wes case referred to medical examiner?  1   Yes   2   No   2   Xec   Injury et   Xec   Injury et   Yes   2   No   2   Xec   Injury et   Xec   Xe	d by the											10	Yes 2,52 No	3 Pro	obably	4 🗌 Unknow
25. Wes case referred to medical exeminer?  1   Yes   2   No    26. Place of Deeth (Check only one)  27. Manner of Death   1   No priesting linestigation   1   Yes   2   No    28. Detection   1   Yes   2   No    29. Accident   1   No priesting linestigation   1   Yes   2   No    29. Accident   1   No priesting linestigation   1   Yes   2   No    29. Accident   1   Yes   2   No    29. Certifier (Check only one)  28. Detection   1   Yes   2   No    29. Detection	t ser the ser	٥												045 14	Mana audai	no. din din no
25. Wes case referred to medical exeminer?  1   Yes   2   No    26. Place of Deeth (Check only one)  27. Manner of Death   1   No priesting linestigation   1   Yes   2   No    28. Detection   1   Yes   2   No    29. Accident   1   No priesting linestigation   1   Yes   2   No    29. Accident   1   No priesting linestigation   1   Yes   2   No    29. Accident   1   Yes   2   No    29. Certifier (Check only one)  28. Detection   1   Yes   2   No    29. Detection	inbe son	E E												6	vailable p	rior to
25. Wes case referred to medical exeminer?    Comparison of the control of the control of the course	aw r	Pe e									_			ő	deeth?	1010000
25. Wes case referred to medical exeminer?  1		5										10	Yes 2 No	1	☐ Yes	2□ No
Yes   20   No   1-2   Impellant   2   ER/Outpetient   3   DOA   4   Nursing Home   5   Residence   6   Other (Specify)	certificat irector, p	0		rred to medical						26. Place	of Deeth	Check only	one)			
Second   S		0		No	Hospitei:	etiant 2	ER/Outpetie	ent 3 🗆 I	DOA	thar: 4 Nurs	sing Ho	me 5 Resi	denca 6 🗆 O	ther (Spec	ify)	
29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29b. Date signed (Month, Dey, Year)  29c. License number  29d. Date signed (Month, Dey, Year)  25d. Date signed (Month, Dey, Year)	Physical distribution		_		28a. Date of Ir	njury		of	28c. Inju	ury et		28d. Describe	how injury occ	urred		
29a. Certifier (Check only one)  29a. Certifier (Sheck only one)  29a. Certifier (Check only one)  29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated.  29c. License number 29d. Date signed (Month, Day, Year)	offine funder	읉	_			Jey rear/	Injury	M			lo					
29a. Certifier (Check only one)  29a. Certifier (Sheck only one)  29a. Certifier (Check only one)  29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated.  29c. License number 29d. Date signed (Month, Day, Year)	f or Attending effer deeth. Director: Afte	ertifica	3 Suicide	6 Could not be determined	286. Pieca of	Injury - At h etc. <i>(Spec</i>	nome, farm, s	treet, facto	ory, office			28f. Location (: City or Tox	Street and Nur wn, State)	nber or Rui	ral Route	Number,
D 16041 MARCH 4, 1999  30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)  TERRY WILLIAMS M.D., MEMORIAL MEDICAL BLDG., CUMBERLAND, MD 21502	Hospi 4 hour Funer tely fill		(Check only		miner: On the basis	of examin										use(s)
D 16041 MARCH 4, 1999  30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)  TERRY WILLIAMS M.D., MEMORIAL MEDICAL BLDG., CUMBERLAND, MD 21502	the city	Med	1	form of Lane	end manner	Stated.			On Lines	se number			29d Data si-	and /Manus	Dev Va	ar)
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) TERRY WILLIAMS M.D., MEMORIAL MEDICAL BLDG., CUMBERLAND, MD 21502	5 1 5 8		AND SIGNAGES AND	10	0	F.										w//
TERRY WILLIAMS M.D., MEMORIAL MEDICAL BLDG., CUMBERLAND, MD 21502	-27		W	nall	ann	(	7		16 ת	041			MARCH	4, 19	199	
TERRY WILLIAMS M.D., MEMORIAL MEDICAL BLDG., CUMBERLAND, MD 21502	6.	5	30. Neme end edd	ress of person who	completed cause of	deeth (Ite	m 23e) (Type	, Print)								
	1	2	TERRY WI	LLIAMS M.	D., MEMOR	RIAL N	MEDICAL	L BLD	G.,	CUMBER	LANI	O, MD	21502			
	Sta	e			32. Regi				4							Yana



State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth **Physician** ANNA PAULINE (SHAFFER) DAUGHERTY March 8,1999 0430 am /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner SACRED HEART HOSPITAL CUMBERLAND If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2♥F 76 Yrs. 215-16-4673 JUNE 12,1922 MARYLAND Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any folury or other traumatic event, the Madical Expanding must be notified an angle. 10b. County 1 ☐ Yes 2 No Director MD ALLEGANY CUMBERT AND 10g. Citizen of Whet Country? 10a. Street and Number 10f. Zip Code 951 SETON DRIVE 21502 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SECRETARY CELANESE FIBERS CORP. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) PAUL HENRY SHAFFER ANGELA GENEVIEVE JENKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) RICHARD J. SHAFFER / BROTHER 2 BUCHANAN AVENUE, LAVALE, MD 21502 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20e. Method of Disposition t 

Burial 2 □ Cremation 3 □ Removal from State RESTLAWN MEMORIAL GARDENS 3/11/99 LAVALE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name end Address of Fecility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD upchurch 23a. Part1. Enter the disease, or comblications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Respiratory failure
Due to (or as a consequence of): /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Non-smallcell carcinones right lung with effusion Examiner physician and the burial-transit certificate be axecuted Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last Due to (or as a consequenca of) P.O. Box 68760. Physician/Medical Due to (or es a consequenca of) 88 usa Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by the a 23h. Did tobacco usa contributa to the causa of death? 1 No 3 Probably 4 Unknown Chanic Lymphostic lenkemin Division of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was an eutopsy performed? Completed Peripheral Vasculer disease 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Offeturel 5 Pending 1 Yes 2 No investigation 2 ☐ Accident 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suiclde 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the ceuse(s) and manner as stated. edical completaly 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only within 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature apd-little of oprifier 121488 mo 1999 March 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 740 Devlin 20 Douglas Ave. Lonaconing, MD ARD To God (Month Day, Year) 32. Registrar's Signature Charles . Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Benjamin Franklin Dorman MARCH 2, 1999 0500 4e. Facility Name (If not institution, give street end number) 4b, City, Town, or Location of Death 4c. County of Deeth PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO | Months | Days | Hours | Min. | S. Date of Birth (Month, Day, Year) | Peb. 17 1911 | Maryland 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign 1 M 2□ F 212-12-3629 Yrs 88 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Wicomico Ouantico 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 23694 Head Of Creek Road 21856 U.S.A 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dales: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorcad Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Joseph Dorman Arietta Dorman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 502 Robinson St.Salisbury, Md.21801 Peggy Smith (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Head Of Creek Cem. Quantico, Md. 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Stewart Funeral Home Stewa West Rd. Salisbury, Md. 21801 23a. Part1. Enter the diffease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Bilat pneumor
Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Probably 4 Unknown 1 Yee. 2 No COPD 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending investigation

Examiner The lew requires that the death certificate be executed Box 68760.

Examiner Physician/Medical ò Completed Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

8

Items 23a

"natural", or

is marked other than

Depertment of Health e Important: If Item 27 Is any Injury or other tra

**Physician** 

/Medical

filed within 72 hours after Hygiene.

Peges 1 end 2 should be 1 sent of Health end Mentel I

Baltimore, Maryland 21215-0020

DURMAN

BENJAMIN

traumatic event, the Medical Examiner must be notified at

Funeral

by

Completed

ettending physician for use es the burie igned by the e page 2 certificate Hospital or Attending Physician: director, filled in by the funeral After s efter death. within 24 hours e To the Funeral D Medical completely To the

State Registrar

P.O. Records. Division of Vital

29b. Signature and title of certifier

6 Could not be determined

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Dete signed (Month, Dey, Yeer)

1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and accress of person who completed cause of death (Item 23a) (Type, Print)

Huddleston M.D.

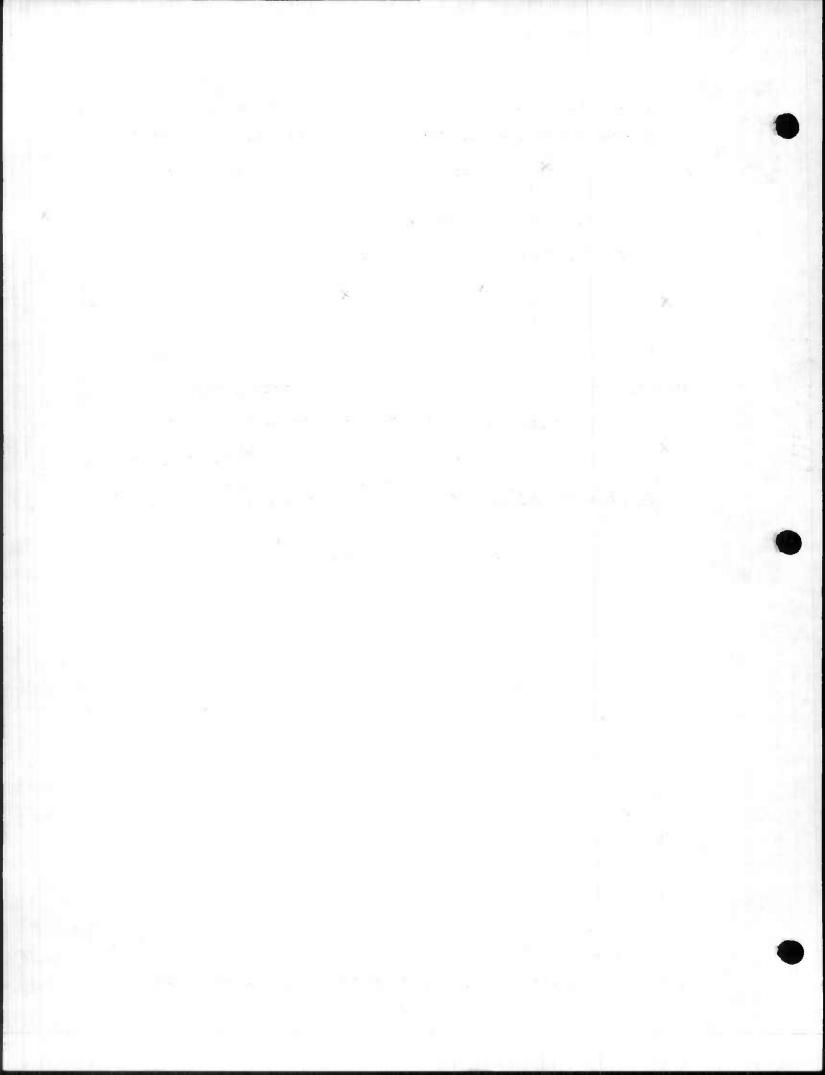
31. Date filed (Month, Dey, Year) MAR 0 4 1999

2 Accident 3 Suicide

4 ☐ Homicide

29a. Certifier





#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 4 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 1999 Evelyn Virginia Dinterman March 7:08 P.M. 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (Stete or Foreign Country) 1 □ M 2 □XF Deys Yrs. 220-26-0720 March 16, 1916 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits XYes 2 No Maryland Frederick Frederick 10g. Citizen of Whet Country? 10e. Streel and Number 10f. Zip Code 21701 27 Winchester Street USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11 Maritel Status Bleck, White, etc. 1 Yes 2 No if Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Merried Specify: White 1 Yes 2 No Specify: 3 ₩idowed 4 Divorced Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) clothing manufacturer presser 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Jesse M. Nusbaum Janie Kinna 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Shirley Burras, Daughter 7114 Bowers Road, Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Slete 1 Buriel 2 □ Cremetion 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) Union Chapel Cemetery 3/10/99 Libertytown, Maryland 22. Name and Address of Fecilit Keeney & Basford Funeral Home 21. Signature of Funeral Service Ligensee 106 East Church Street, Frederick, MD 21701 M00999 Deiger 23e. Part L. Entur he disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse of each line. Approximate Intervel Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in deeth) · EMPHYSEMA 20 yrs Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 ⊠npalienI 2 ☐ ER/Oulpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

physician and the burial-transit the death certificate be executed Division of Vital Records, P.O. Box 68760, attending phy signed by the a been si page 2 certificate or Attending Physician: this funeral After death. after deat Director:

Physician/Medical by Completed Be 2 Certification:

Medical

State

Registrar

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

by

Completed

2

Examiner

**Funeral** 

**Director** 

with the Manyland

permit. Pages 1 and 2 should be lifed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow any highry or other traumatic event, the Medical Examines must be notified at once.

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

n 24 hours after dea ne Funeral Director pletely filled in by th To the Hosp within 24 ho To the Fune completely fi

(Check only one) 29b. Signeture end title of certifique

29a. Certifier

29c. License number

2 Madical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Dey, Year)

Waru

D47611

1X Certifying Phyalcian: To the best of my knowledge, death occurred at the time, dele and piece, and due to the cause(s) and manner as stated.

3-8-99

30. Neme and address of person who completed cause of deeth (ftem 23e) (Type, Print) 1475

TANEY AVR FREDRUCK MD 21702

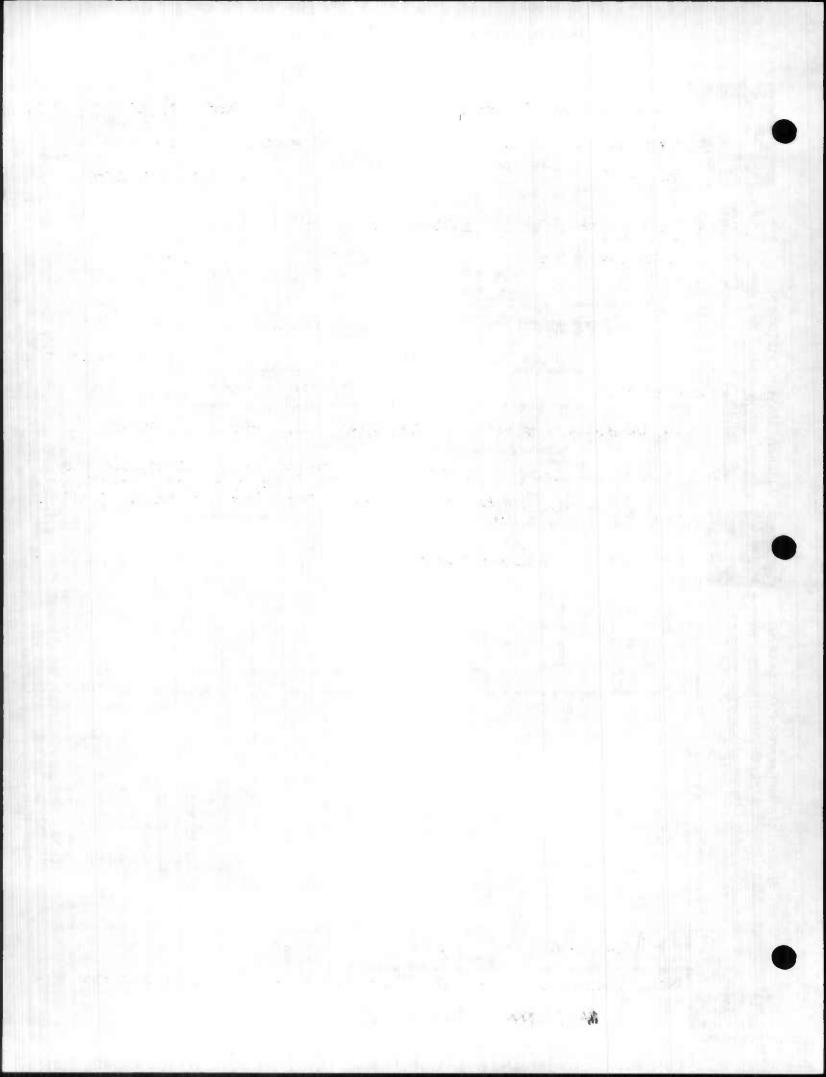
MARAYPEICAN 31. Dele filed (Month, Day, Year)

32. Registrer's Signeture

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MAR 1 0 1999

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State

Registrar

nonald

31. Dele filed (Month, Day, Year)

MAR 05

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

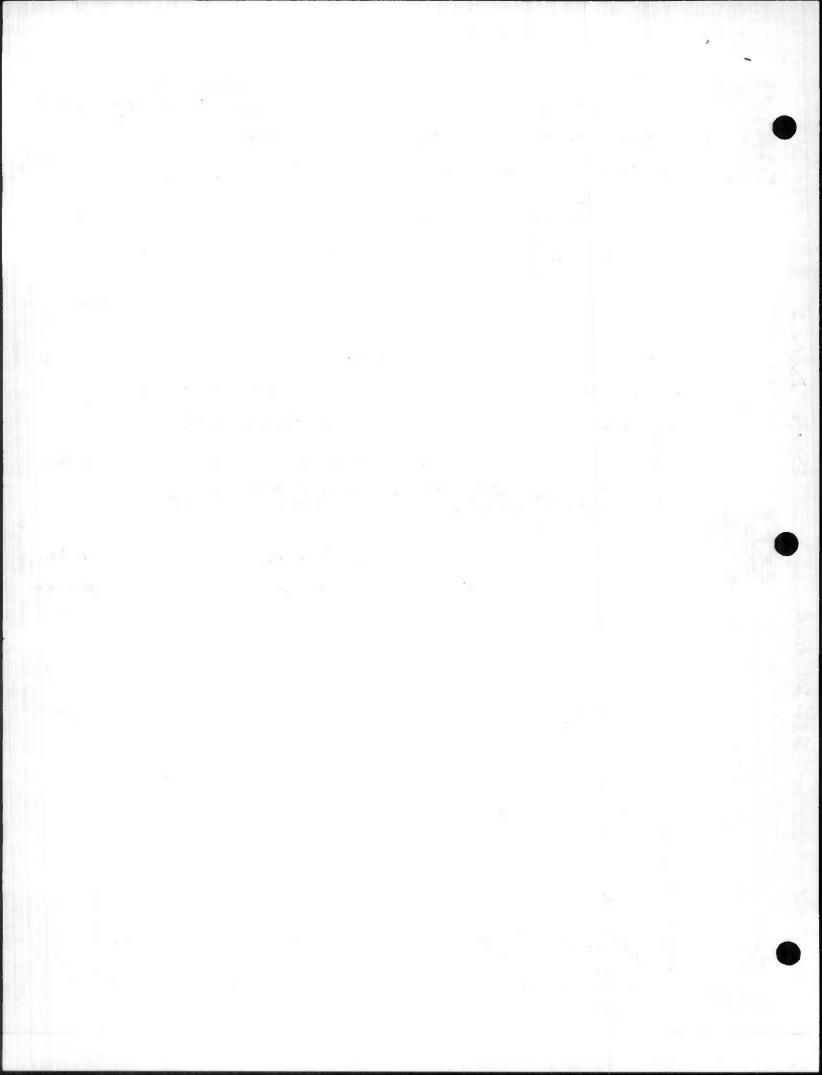
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Riverside

32. Registrer's Signeture

Jalisbury, md. 21801

222-24-412



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** MADGALENE DUVALL 5:30 pm MARCH 2 1999 /Medical 4a Facility Nama (If not institution, give straet and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNAPOLIS NURSING & REHAB. ANNAPOLIS | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month), Day | 9. Birthplaca (Stata or Foreign Month), Days | Hours | Min. | F.E.B. | 1 9 0 2 | MARYLAND 9. Birthplaca (Stata or Foraign 5. Social Sacurity Number 7. Age (In yrs. last birthday) **Funeral** 10M QDF 97 Yrs. 212-32-1329 Director Usual Rasidence of Dacedani the Maryland 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Medical Examinar must be notified at MARYLAND ANNE ARUNDEL ANNAPOLIS 1 Yas 2 □ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21403 US 1313 MCKINLEY STREET Funerai death 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or free ony Injury or other traumatic avent, the Medical Exercises pages. 1 ☐ Yes 2 No If Yas, Give Yaar or Datas: 1 Naver Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: by 3 MWidowed 4 □ Divorced BLACK Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16h Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) OUT OF THE HOME 7th
17. Father's Name (First, Middle, Last) DOMESTIC 18. Mothar's Nama (First, Middla, Maidan Sumame) blanche murray moses gross 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code)
1214 STANSFIELD DR. FAYETTEVILLE, N. 28303 19e. Informant's Name/Relationship (Type, Print) BLANCHE E. DAY (NEICE) 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Data 1 ® Burial 2 ☐ Cremation 3 ☐ Ramoval from State 3/6/99 ANNAPOLIS, MD. 4 ☐ Donation 5 ☐ Othar (Specify) ANNAPOLIS NECK CEME. 21. Signatura of Funaral Sarvice Licansaa 22. Nama and Addrass of Facility WM. REESE & SONS MORTUARY, P.A. eese 821 WEST ST. ANNAPOLIS, 23a. Part1. Enter the disasse, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intarval Batween Onset and Death **Physician** onschensis - severe /Medical Immediete Ceuse (Finel disaasa or condition resulting in daath) carl Examiner Dua to (or as a consequance of) Examiner requires that the death certificate be executed physician and s the burial-trans Sequantially list conditions, if any, laading to Immadiata cause. Enter Undarfying Cause (Disaasa or injury that Initiated events resulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequanca of): 88 950 jo Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the à 1 Yes 2 No 3 Probably 4 Unknown signed ! þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 certificate has 1 ☐ Yes 2 ☐ No funeral director, 25. Wes cesa referred to medical axaminar? Be 26. Place of Death (Check only ona) Hospital: Othar: Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 XNO 2 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Mennar of Death 28a. Dete of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Attending 5 Panding 1 Natural efter death. Director: Aft 1 Yas 2 No Invastigation 2 Accident 6 Could not be detarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida ò Hospital 24 hours Funeral 29a. Cartifiar 📂 Sertifying Phyeiclan: To tha best of my knowledga, daath occurred at tha time, data and plece, and due to tha ceusa(s) end mannar as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. To the F within 2 29b. Signatura and titla of certifie 29c. Licanse number 29d. Data signed (Month, Day, Year) 30. Neme and address of person who complated causa of death (Itam 23a) (Type, Print) Ave 205 20 31. Date filed (Month, Day, Yaar) MAR 0 8 1999 32. Registrer's Signature

Registrar

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Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** March 4 1999 11:05 am James Edward Droppleman /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner Garrett Oakland Garrett Co. Memorial Hospital if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□ F Yrs. 220 16 6880 W. Va Sept 22 1921 **Director** Usual Residence of Decedent the Marylend 10e State 10b Count 10c. City. Town or Location 10d, fnside City Limits "natural", or items 23s or 28s-f show 1 Yes 2 No Kitzmiller Garrett Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 21538 USA pemit. Pages 1 and 2 should be filed within 72 hours after deeth v. Department of Health end Mental Hygiene. Important: If fem 27 is marked other than "natural", or frams 23a any Injury or other traumatic event, the Medical Examine Investigation. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 12. Was Decedent Ever in U,S. Armed Forces? 11 Maritel Stetus Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 27 Married Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Coal Coal Miner 18. Mother's Name (First, Middle, Malden Sumame) 17. Fether's Name (First, Middle, Last) Be John Droppleman Margaret Hickey 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kitzmiller, Md PO Box 431 Mildred Droppleman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burlal 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mar 6 1999 Elk Garden W. Va Kalbaugh Cemetery 22. Name and Address of Facility 21. Signature of Funerel Servica Licenses David A. Burdock FH 710 Church St. Kitzmiller Md 21538 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strick, or heart feiture. List only one ceuse on each line. Approximate Interval Between Onset end Deeth **Physician** /Medicai Immediate Ceuse (Final diseese or condition resulting in death) ACUTE MI IMMEDIATE Examiner Due to (or as a consequenca of) Examiner ASHD WITH ANGINA (1 Yr physicien and the burial-transit The law requires that the deeth certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequenca of) 88 attending p signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SOUAMOUS CELL CA LUNG by 24b. Were autopsy findings available prior to completion of cause of death? been si 24a. Was an autopsy performed? Completed HBP irector, page 2 s 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Thpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes this funeral 28d. Describe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: Aftert 5 Pending investigation Netural 1 Yes 2 No within 24 hours aftar deeth To the Funeral Director: A completaly filled in by the f 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. Medical (Check only one) To the I within 2

29c. License number

21550

4th St Oakland, Md

29d. Date signed (Month, Day, Year)

DALVA

Division of Vital Records. P.O. Box 68760.

State Registrar 29b. Signature and title of contifler

Thomas G.

31. Date filed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

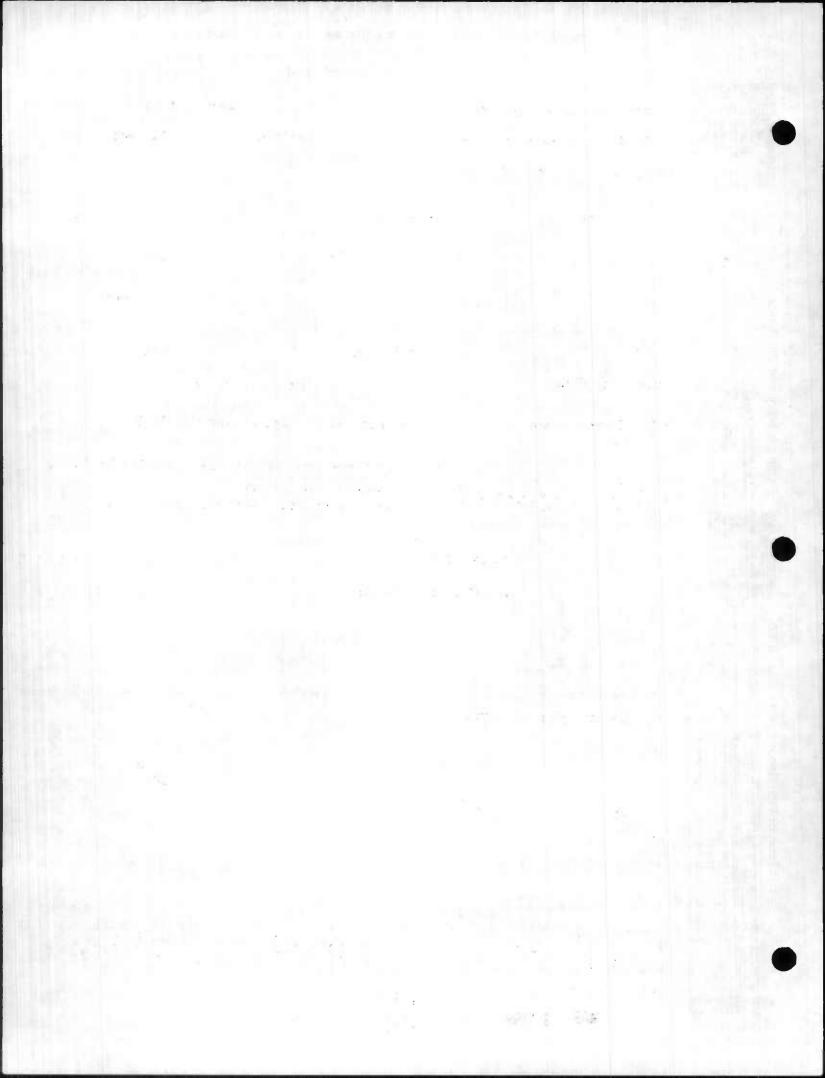
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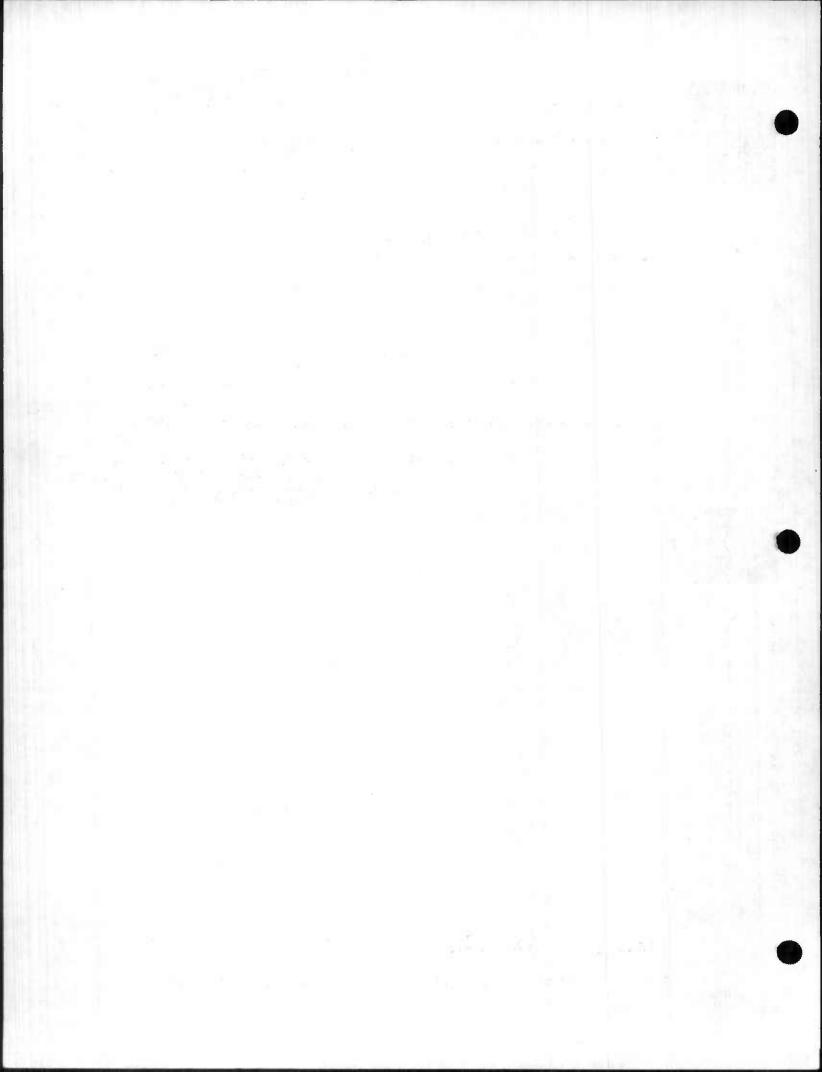
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**DHMH 16 Rev 6/95** 



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dent's Name (First, Middle cedes Echem						2. Dete of Deat			3. Time of Deeth
4a. Facility Neme (If not institution, give street end number)  Mariner Health @ Circle Manor						Month	8, 199	Year 9	8:54PM
lity Neme (If not institution	n, give street end nu	m <i>ber)</i>			4b. City, Town, or I		4c. County		0.54111
iner Health	@ Circle	Manor		1	Kensingto	n	Monte	omery	
Security Number -82-3210	6. Sex 1 □ M 2 🛣 F	7. Age (In yrs.		If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Jan. 1,	Year) 1910	9. Birthpla Country Cuba	ce (Stete or Forei
Residence of Decedent ate 10b. County		10c. Ci	ty, Town or Loc	cation				100	d. Inside City Llm
Montg			thesda						1 ☐ Yes 2 ☒ I
erly House A	4521 Eas partments	t West Bethesd	Highway a, MD	7 10f. Zip Code	20814		10g. Citizen of Whet Country? USA		y?
itai Status Never Married 2□ Merr Widowed 4□ Divorced	Armed For	2 to No ve	. If	Vas Decedent of I Yes, specify Cub ☐ Yes 2 ☑ No	dispanic Origin? (Si an, Mexican, Puerto Specify:	pecify Yes or No- Ricen, etc.)		e - American k, White, etc. B1a	c.
15. Deceden (Specify only higher entery/Secondary (0-12)	t's Educetion st grede completed) College (	1-4or 5+)	(Give I	O NOT use retire	during most of won	king	16b. Kind of Bu	siness/indu	stry
O	J and		House	ekeeper	40.34 4.34		N/A		
ner's Neme <i>(First, Middl</i> e, Unk:	nown Eche	menbia				ne <i>(First, Middle, M</i> .known Un		θ)	
formant's Name/Relations	hlp (Type, Print)		19b. Maijin	g Address (Street	end Number or Ru			Stete. Zin C	ode)
Julio Alv		ia/frie							
thod of Disposition		20b. F	Place of Dispos	sition (Neme of setory or other ple			20c. Location -		n, Stete
Burial 2 ☐ Cremetion Donation 5 ☐ Other (Si		State	-	eaven Cer		/12/99	Silver	Sprin	g, MD
neture of Funeral Service	Licernan	1	Ho S i	Name end Addre	ss of Facility Fr. 500 Uni	ancis J.	Collin	s Fun	
art1. Enter the disease, or lock, or heart failure. List	complications that conly one cause on e	eused the deat each line.						A	pproximete ntervel Between Inset end Death
ate Cause (Finel or condition g in death)	Θ	Sep	ticemia	1				2	days
j iii Qoaur)		Due to (d	or as a consequ	uence of):					
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.									
Cause (Disease or injury that initiated events resulting in death) Lest  Due to (or as a consequence of):  Due to (or as a consequence of):  Description of the initiated events resulting in the underlying celebration with hypernatremia:						of):			
Other significant conditio	ns contributing to de	eath but not res	uiting in the un	deriving ceuse giv	en in Pert I	23b. Did to	hacco use con	tribute to th	he cause of dear
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Alzheimer's dementia						24a. Was ar perform	n autopsy ned?	aveile	autopsy finding able prior to detion of cause ath?
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cese referred to medical miner?	Hospital:					th (Check only one	9)		
Yes 2.21 No ner of Death Natural 5 ☐ Pendin	3 DOA Oth	y at k?	ome 5 Reside 28d. Describe ho						
Accident investig Sulcide 6 Could r Homicide determine	not be	M 1□ ei, factory, office	Yes 2 □ No	28f. Location (Sti City or Town	reet end Numbe , Stete)	er or Rurel F	Route Number,		
27. Manner of Death 1						and due to the ca red et the time, de	use(s) and men te end plece, a	nner as state	ed. ne ceuse(s)
						29	d. Date signed	(Month, Da	ıy, Year)
Martin C Shere & D08944							3/9/9	9	
e and address of person i									
Person (									
n)	ture and title of certifier	and meniture and title of certifier  Western C See and address of person who completed ceut	and menner stated.  Iture and title of certifier  Watture and address of person who completed ceute of death (iten	and menner stated.  Iture and title of certifier  Watter C S S S S S S S S S S S S S S S S S S	and menner stated.  29c. Licens  D08  and address of person who completed ceute of death (item 23e) (Type, Print)	and menner stated.  29c. License number  D08944  and address of person who completed ceute of death (item 23e) (Type, Print)	and menner stated.  Attree and title of certifier  29c. License number  D08944  and address of person who completed ceute of death (Item 23e) (Type, Print)	and menner stated.  29c. License number  D08944  3/9/9  and address of person who completed ceute of death (Item 23e) (Type, Print)	and menner stated.  29c. License number  D08944  29d. Date signed (Month, Date 3/9/99)



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Charles 7, Endzel, Jr. 1999 March 2:30P. 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) 5511 Taylor Road Prince George's Riverdale Park If Under 1 Yeer 5. Social Security Number If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Days Months XXM 20 F 68 Yrs. 218-24-3265 March24, 1930 New Jersey Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. inside City Limits Maryland Prince George's Riverdale Park 1 ☐ Yes XX No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5511 Taylor Road 20737 United States 12. Was Decedent Ever in U,S. Armed Forces? XXX Yes 2 □ No I Yes, Give Year or Dates: 1947–1950 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Biack, White, etc. 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Commercial Artist Self employed 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charles Endzel, Sr. Amelia Pulasky 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Jane Endzel (wife) same as #10 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removel from State Maryland Veterans Cemetery 3/12/1999 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 21. Signature of Funerel Service Licer 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or conducations that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) Due to (or es e consequence of) Rectal Carañoma Due to (or es e consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes XX No 3 Probably 4 Unknown

**Physician** /Medical Examiner

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Director: /

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The law requires that the death certificate be axecuted

Box 68760

Division of Vital Records,

or Attending Physician:

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death.

Physician/Medical Examiner

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Completed

Be

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Certification:

Medical

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

28a-f show

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Funeral

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Completed

/ is marked other than "natural", or items 23s or 28s-f show trsumetic sysut, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death a Depentment of Haaith and Mental Hygiene. Important: If itsm 27 is marked other than "natural", or thems 23. any fijlury or other traumatic avant, the Menter Experiment.

Baltimore, Maryland 21215-0020

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Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting In death) Last

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 XXIO 1 Yes 2000 26. Place of Death (Check only one) Other: 4 Nursing Home XX Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

25. Wes case referred to medical examiner? 1 Yes XX No 27. Manner of Death 1 XX aturel 5 Pending Investigation 2 Accident

28a. Dete of Injury (Month, Dey Year) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? 1 Yes 2 No

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

Certifying Phyaician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated.

Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature end title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D26250

3/9/1999

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

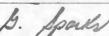
Matilda So, M.D. 10810 Connecticut Avenue, Building2 Kensington, Maryland 20895 31. Date filed (Month, Day, Year)

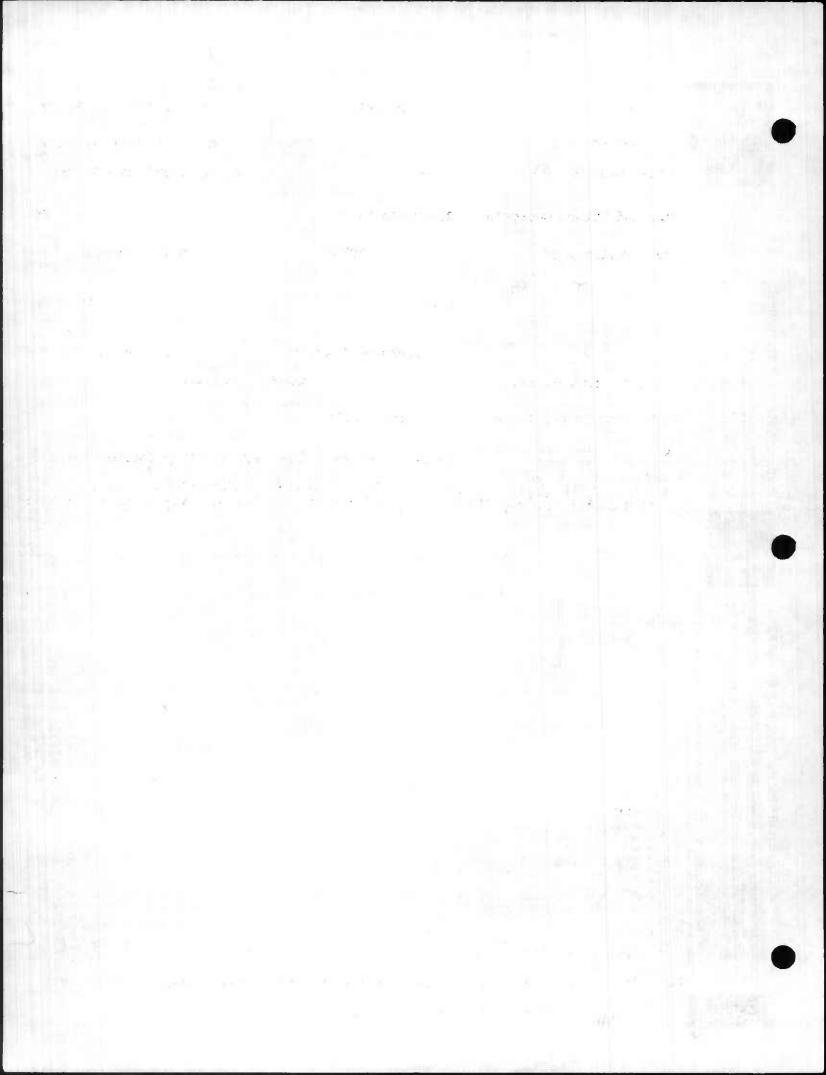
State Registrar

MAR 1

6 Could not be determined







State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death .<sup>Da</sup>1999 Month March 9, 1:05 PM Ericson 4b. City, Town, or Location of Death 4c. County of Deeth Prince George's

10d. Inside City Limits

1 Yes 2 No

20910

Approximate tnterval Between Onset and Death

10 years

1 ☐ Yes 2 ☐ No

**Physician** William В. /Medical 4a Facility Name (If not institution, give street end number) Examiner Clinton Southern Maryland Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Dec. 30, 1924 New York 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 10 M 20 F 126-14-6799 74 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 28a-f show Directo Prince George's Clinton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 20735 United States Berns 23a 9408 Fletcher Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1\(\sum \) Yes 2 \(\sum \) No If Yes, Give Year or Dates: WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. hours after 1 Never Married A Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Specify: White ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Federal Communication College (1-4or 5+) Elementery/Secondery (0-12) Commission 5+ Physicist / Engineer permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is manked other any Injury or other treatmetic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cornelia Lance John William Ericson 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 9408 Fletcher Avenue, Clinton, Maryland 20735 Gloria H. Ericson 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State University of Health 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 3-11-99 Bethesda, Maryland Science S<sub>22. Name and Address of Fecility</sub>
Rapp Funeral Services, P.A. 21. Signature of Funeral Service Licenses ekm 933 Gist Avenue, Silver Spring, Maryland 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final Metastatic Prostate Cancer disease or condition resulting in death) Examiner Due to (or es a consequence of): Physician/Medical Examiner sician and burial-transit Hospital or Atlanding Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria P.O. Box 68760. Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 ☒ Unknown 1 Yes 2 No signed b Division of Vital Records. þ 24b. Were sutopsy findings available prior to completion of ceuse of death? Be Completed 24a. Was an autopsy 1 Yes 2 No funeral director, 25. Was cese referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) edical Certification; To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 1 Netural 2 Accident 5 Pending 1 Yes 2 No investigetion 6 Could not be determined within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier To March 10, 1999 D46246

Registrar

State

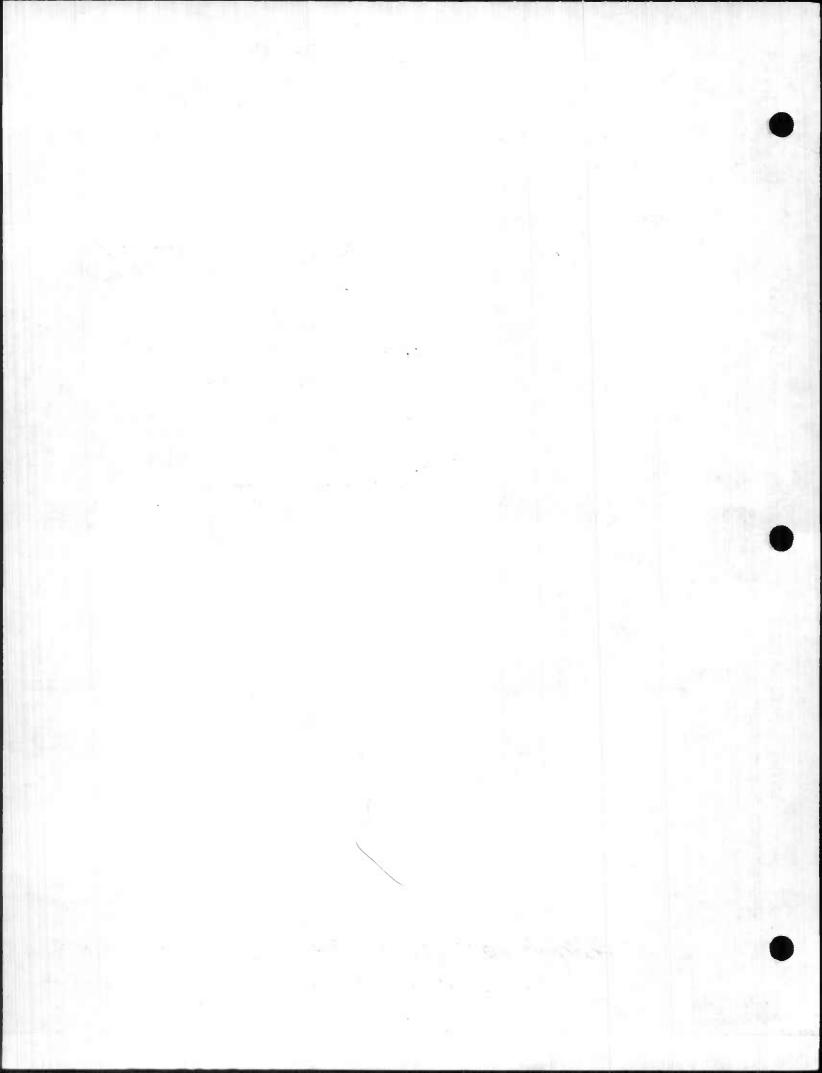
Ashraf Meelu, M.D., 2 St. Patrick's Drive, Waldorf, Maryland

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

1999

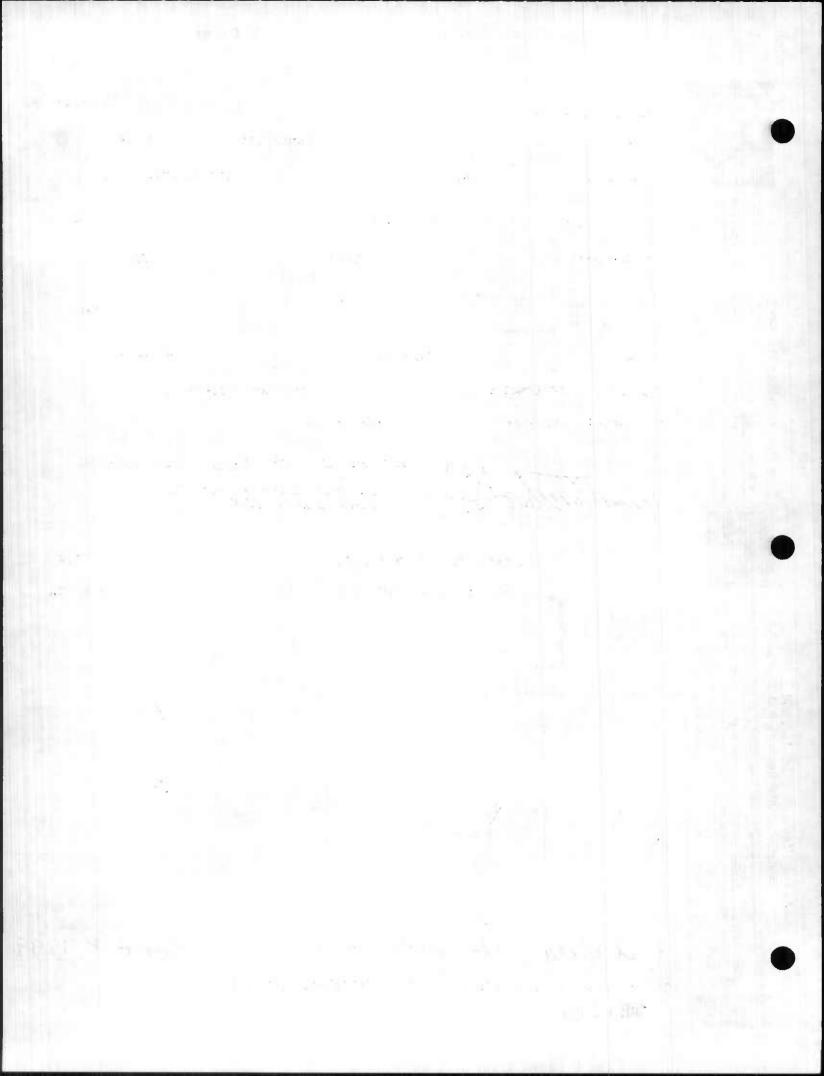
31. Date filed (Month, Day, Year)

MAR 12



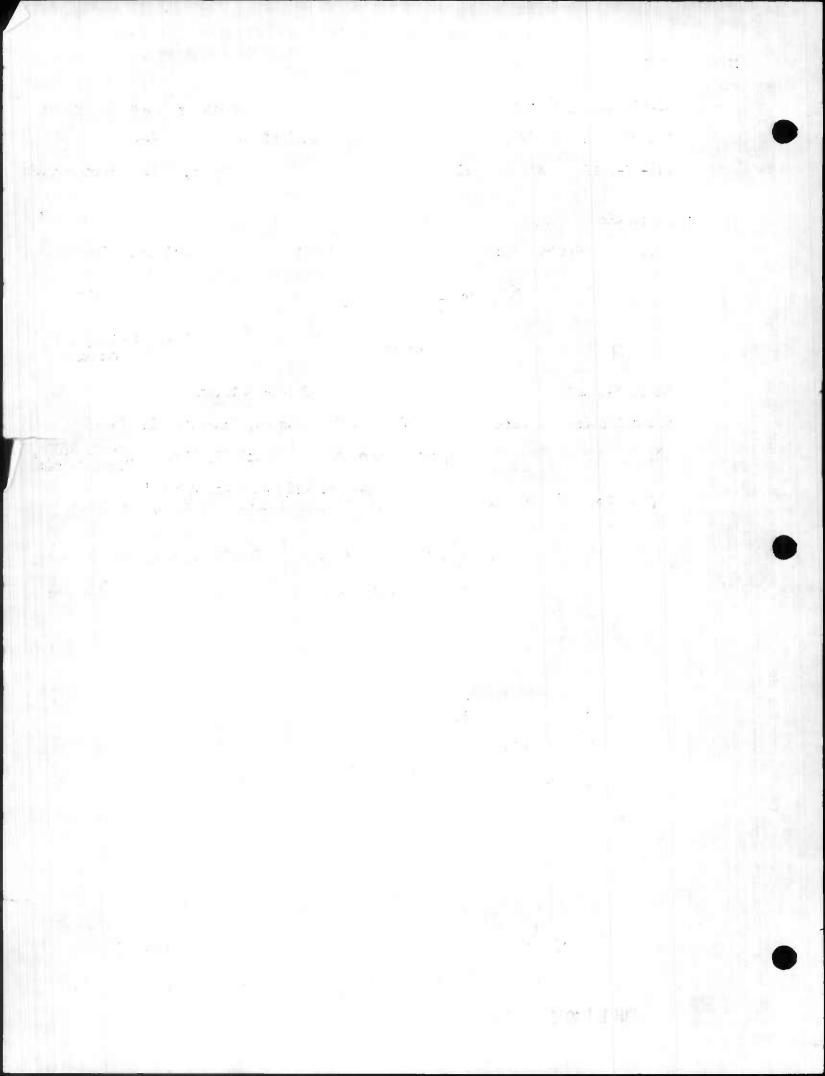
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al or	214-05-8858	DM 2K)F	e (In yrs. lest b 87	Yrs. If Und Month	ler 1 Yee s Days		Min.	Dec 2,	Year) 1911	9. Birthp Coun WV		r Foreign
	Usual Residence of Decedent  10a. State 10b. County		10c. City. To	wn or Location						1	0d. Inside Ci	tv Limits
٥	100			erland							1√2 Yes	
Director	Allegany 10e. Street end Number	/	Cumb		Ip Code			10	og. Citizen of	What Coun	atry?	
ă		0.5			•	,					, .	
Funeral	110 Springdale	12. Was Decedent	Ever In U.S.	13. Wes Dec	21502 redent of	Hispanic Orig	in? (Spec	ify Yes or No-	US 14, Rad	A - Americ	an Indian,	
	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 2	No	If Yes, sp	ecity Cu	ban, Mexican,	Puerto Ri	ican, etc.)	Bla	ck, White,	etc.	
-	3√2 Widowed 4 □ Divorced	It Yes, Give Year or Detes:		1 ☐ Yes	3€ NO	Specify:			Specif		white	
,	15. Decedent's Ed	ucation	16	a. Decedent's Us	suel Occu	upation	of working	. 1	16b. Kind of B			
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Be	17. Fether's Neme (First, Middle, Last)					18. Mother	r's Neme (	First, Middle, N	feiden Sumer	ne)		
2	Zebulon A. Brai	thwaite				Rose	eann	(Aldert	on)			
	19e. Informant's Name/Relationship (7			b. Mailing Addre			r or Rurel	Route Number,	City or Town	, State, Zip	Code)	
	Elma Kennell-dau	ghter	-	Gettysbu		PA						
	20a. Method of Disposition 1	Removal from State	20b. Place cemet	of Disposition (A ery, cremetory o	r other pi	eca)	i	Date 2	20c. Location	- City or To	own, State	
	4 Donetion 5 Other (Specify		Hillo	crest Me	mori	al Par	$k \mid 0$	3/08	Cumber	land	MD	
	21. Signature of Funeral Service Licens	1/2/	1	Sca	rpe]	ress of Fecility	eral	Home,	P.A.			
	23a Part1 Enter the disease or com	alloations that caused	OFFITTENED D	Cun	ber]	land MD	2150	02 respiratory arre	et	1	Approximat	
	23a. Part1. Enter the disease, or composition of the shock, or heert feilure. List only of	one ceuse on each lir	10.					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			tntervat Bet Onset and	ween
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Med	resulting in death) Lest									1		
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Physician/	Part It. Other significant conditions co	entributing to death be	ut not resulting	in the underlying	cause	iven in Pert I.		23b. Dfd to	bacco use co	entribute to	the cause	of death?
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Completed by								24a. Was er	n eutopsy ned?	ev	ere autopsy i allebte prior i	0
pie										of	mpletion of death?	ause
5								1 ☐ Ye	s 2 No	1	Yes 2□	No
Be C	25. Was case reterred to medical					26. Ptece	of Deeth	(Check only on	в)			
20	exeminer?	Hospital: 1 tnpatie	nt 2 ER/C	Outpatient 3	DOA	ther: 4 Nur	rsing Hom	e 5 🗆 Reside	nce 6 Ott	ner (Specif	(y)	
	27. Mariner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju	ry 28b	. Time of Injury	28c. Inj W	ury at ork?	28	d. Describe ho	w injury occu	rred		
alle:	2 Accident investigation			М		Yes 2 N	10					
cer micanon.	3 Sulcide 6 Could not be determined	28e. Place of Injuding, etc.	ury - At home, c. (Specify)	ferm, street, fact	ory, office	Э	28	St. Location (Sti City or Town		ber or Rura	Il Floute Nun	ber,
edical		/eician: To the best of iner: On the basis of										;)
Med	one)	end menner sta										
	29b. Signature and title of certifier	V		1111		nse number		25	od. Date signe			700
	· Wille	n Or	mi	W	D 25	406		1	IAR	H	8,10	14
1	30. Name end address of person who o	completed cause of d	eeth (Item 23e	) (Typa, Print)								
1	WILLIAM LAMM M.D.	, 47 VIRG	INIA AV	/E., CUM	BERL	AND, M	D 21	1502				
е	31. Date fited (Month, Day, Year)	32. Registr	ar's Signetur	dan	the !							



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	15: #	5 PER F.H. G769 3-29-99 WR.	Certifica	te of	Death		eg. No.	UJ	3. Time of Death
Physi		1. Decedent's Name (First, Middla, Last)  Donald Harvey Emerick				2. Date of Deat Month MARCH		Year	
/Med Exam		4a Facility Name (If not institution, give street and number) Sacred Heart Hospital			4b. City, Town, or Lo Cumberlan	cation of Death	4c. County of	of Death	8:20AM
Funera Directo			11 110. 1401 01101041	er 1 Year s Days		8. Date of Birth Month, Day. May 26		_	ace (Stata or Foreign ny) INS YLVANIA
ahow det			Oc. City, Town or Location						d. Inside City Limits
h the Me r 28a-f s	recto	ennsylvania Bedford  100. Street and Number 3571 Hundman Road	Hyndman 101.2	ip Code		1	0g. Citizen of W	hat Count	1 ☐ Yes 2 🕅 No
23a c	raiD	3571 Hyndman Road			5545		United S		
5-UUZU 72 hours efter deeth with the Meryland naturel', or items 23s or 28s-f show	by Funeral		59⊾ 1□ Yes	2 No				- America , White, e Whi	tc.
5 . 5	Completed	15. Decedent's Education (Spacify only highest grada complated)  Elementery/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Us (Giva kind of the DO NOT Laborer	uai Occu vork dona usa retire	pation during most of workind)	ing	16b. Kind of Bus Kelly Sp	oring	field
be file d other	To Be Co	17. Father's Name (First, Middla, Last)  Merle Emerick			18. Mother's Name			Com	pany
2 should end Men is marks	F	19a. informant's Name/Relationship (Type, Print)	19b. Mailing Addre	ss (Straa	t and Number or Rura		; City or Town, S	Stata, Zip	Coda)
こうだと		Norma Emerick Spouse	PO Box		Hyndman,		lvania	1554	
Peges nent of int: If its		(0,7//	20b. Place of Disposition (N comatary, cromotory o Lyburger Cem				999 Bu	iffal	lo Mills,
permit. Pe Depertmen Important: any injury	0000	21. Signature of Funeral Service Licansee  Danda J. Putting  23a. Part1. Enter the disease, or complications that caused he shock, or heart failure. List only one cause on each line.	Harv	eu H.	ess of Facility . Zeigler ence Stroo	Funeral t Hun	Home?	DUNKI	Prania
eath certificate be executed  Example of the control of the contro	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e to (or as a consequence of the	):	most a	, o the a	Neursy	2	2 maths a years
. 0 00	Physician/M	Part ii. Other significant conditions contributing to peath but r	not rasulting in the underlying	cause gi	ven in Part i.	23b. Did to	bacco uae con	tribute to	the cause of death
het the	by Phy	i) rend tail	we			ixy	es 2 No	3 Prob	ably 4 ☐ Unknow
hes been sign 29 2 should t	Completed	y choleuphitis	1	1	1 7:	24a. Was a perform	n autopsy med?	ave	re autopsy findings iliable prior to apletion of cause leath?
ysician: The l s certificate he director, page		1) parcy cottie	4) Ischemia of	1024	. Atlantic	5 10 Y		1 🗆	Yes 2000
To the Hospital or Attending Physician: The law requires twithin 24 hours after deeth.  To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be.	Certification: To Be	25. Was case referred to niedical examiner?  1	- At home, farm, street, fact	28c. inju Wo	Yes 2 No	me 5 Reside	enca 8 Other	bd	
pspital or hours afte ineral Dire	sai Cert	29a. Certifier Dullding, etc. (	ny knowledge, deeth occurre				ause(s) and mer		
To the H within 24 To the F.	Medical	(Check only one)  2 Medical Examiner: On the basis of exand manner state.  29b. Signature and title of certifier.	d.		se number		9d. Date signed	(Month, L	Day, Year)
/	0	30. Name and address of person who completed cause of deal	h (Item 23a) (Type, Print)	L	, , , , , , ,		MARCH	8	1999
w	)	Kurchal I Ma Gail	Co L	. 11	Cural- 1		1111 -	1	



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 2. Dete of Deeth 1 Decedent's Name (First, Middle, Last) **Physician** vesor 0231 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Name (If not institution, give street and number) Mary and Medical System Examiner 1mversing of Baltimore If Undar 24 Hrs 8. Data of Birth (Month, Dey, Yeer) 5. Sociei Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2ÅF Days Hours 51 504-56-8542 Yrs 8, JAN. SOUTH DAKOTA **Director** Usuei Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. net of Health and Mental Hygiene. nt: If Item 27 te marked other than "natural", or Items 23a or 28a-f show 10a. Stete 10c. City, Town or Location 10d. inside City Limits 10b. County 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Directo MARYLAND ANNE ARUNDEL LINTHICUM 10g. Citizan of What Country? 10e. Street end Number 10f. Zip Code 21090 110 KINGBROOK ROAD U.S.A. Funerai 14. Rece - American Indian, Bieck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Married 1 ☐ Yes 2 No If Yas, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cottege (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) ROY SANFORD PAPIK CLARICE LORRAINE LARSEN 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) ROGER CURTIS EVESON (HUSBAND) 110 KINGBROOK ROAD, LINTHICUM, MARYLAND 21090 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 3/11/99 Buriei 2 Cremetion 3 Removei from Stete = 5 Department of important: If any Injury or 4 Donetion 5 Other (Specify) EPIPHANY EPISCOPAL CHURCH CEMETERY ODENTON, MD. 22. Name and Address of Fecility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 come cause that caused the beth. Do not enter the mode of dying, such es cardiac or respiratory errest, only one cause on each line. Approximate intervei Between Onset and Death Physician Hemorrhage /Medical Immediate Ceuse (Final Cerebral 8 hours disaesa or condition resulting in deeth) Examiner Examiner roke UNKNOWN physician and the burial-transit requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequença of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequenca of) 60 989 signed by the a 23b. Did tobacco use contribute to the cause of death? Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were eutopsy findings evailable prior to Completed 24a. Wes en eutopsy performed? completion of cause of deeth? page 2 has 1 Yes 2 No 1 Yes 2 No certificate or Attending Physician: director. 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Dele of tnjury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. injury et Work? 1 Naturet 5 Pending 1 Yes 2 No death. investigation 2 Accident after death Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 | Homicide hours a 24 hours Hospital 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) and menner stated. 29a. Certifier Medicai completely (Check only one) To the Within 2 29b. Signatura and titia of curtifier 29c. Licanse number 29d. Dete signed (Month, Dey, Year) will 30. Name end eddress of son who completed cause of deeth (item 23e) (Type, Print) inch 20 South Greene Street Baltimore, Md. 21201 hristo 3. Registrer's Staneture 31. Dete filed (Month, Day, Year) State MAR 1 0 1999 Registrar

State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) March 6, 1999 **Physician** 3:26PM Robert E. Erwin /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Feclity Neme (If not institution, give street end number) Examiner North Arundel Hospital Glen Burnie Anne Arundel 8. Dete of Birth (Month, Den Year) 9. Birthpleca (Stete or Foreign Aug. 28, 1923 Washington, DC If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthpleca (Stete or Foreign **Funeral** Months Deys Hours 170 M 2□ F 579-20-5244 Yrs. Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: If tam 27 is marked other than "natural", or items 23s or 23s-1 show any injury or other traumatic event, the Medical Expriner must be notified and 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes No Maryland Anne Arundel Glen Burnie Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21061 USA 350 Highland Dr. Apt. 103 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2√ No Specify: by 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Highs Store Elementary/Secondary (0-12) College (1-4or 5+) Self-employed 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Be James Erwin Louise Adrian 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Shirley J. Greever/Daughter 1237 Prince St. Dunkirk, MD. 20754 Method of Disposition

1 Burial 2 Cremation 3 Reprovation State
4 Donetion 5 Dother (Specify) Entromblient

20b. Plece of Disposition (Name of cemetery, crematory or other plece)
Hillcrest Cemetery 20c. Location - City or Town, Stete 20e. Method of Disposition 3/10/99 Annapolis, MD. 21. Signature of Juneral Service Licensee Ceorge P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD. Maused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest Approximate Interval Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical 2 days Sepsis Examiner Due to (or as a consequence of): Examiner physician end the burial-transit the death certificate be executed Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): ettending ph for use es t signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown thet Division of Vital Records. by The law requires 24b. Were autopsy lindings evelleble prior to completion of cause of death? should 1 24e. Wes en eutopsy performed? Completed certificate hes b 1 ☐ Yes XX No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certifica 25. Was cese referred to medical examiner? VY 1 ☐ Yes 2 ☐ No Be 26. Plece of Deeth (Check only one) Hospital: XX Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) à 4 Homicide 24 hours Funeral Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as steted. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medicai 2 Medical Examiner: On the basis of examinetion end/or Investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D51010 March 6, 1999 30. Name and address of personamo completed cause of death (Item 23e) (Type, Print) Muhammad-Ali A. Zaydan, M.D. North Arundel Hospital Glen Burnie, MD.

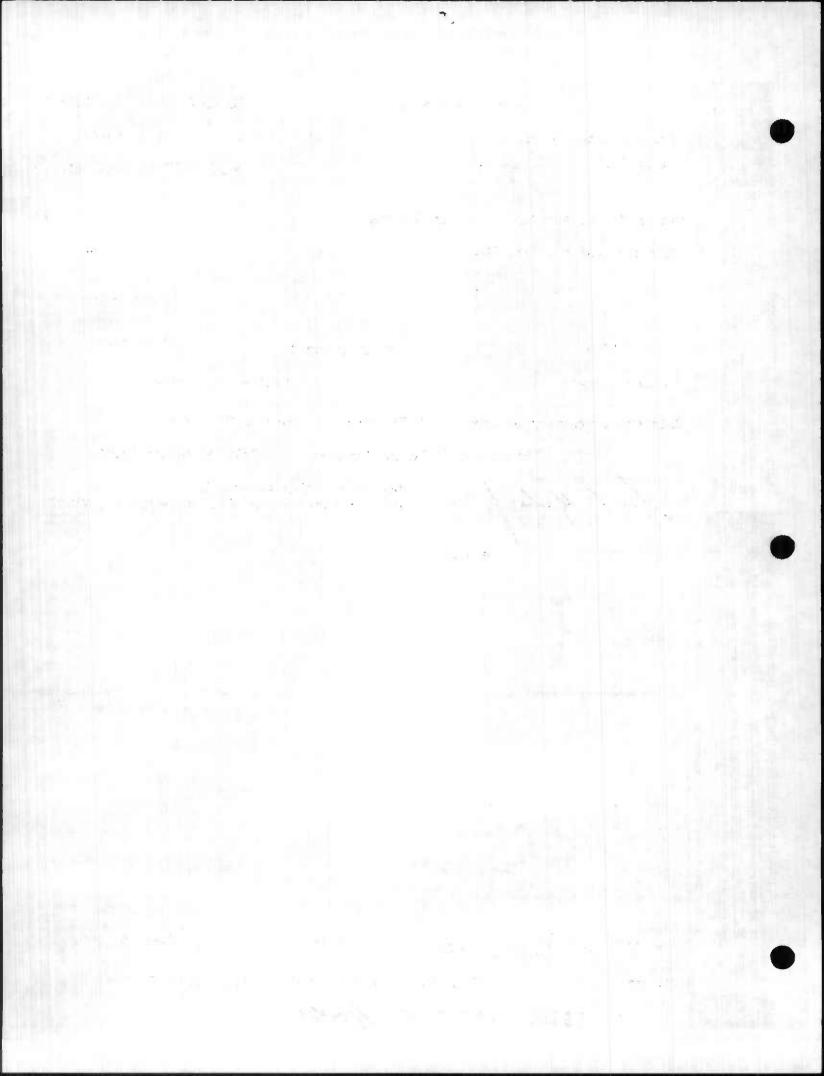
Registrar

31. Dete filed (Month, Dey, Year)

0 9 1999

32. Registrer's Signeture

borks

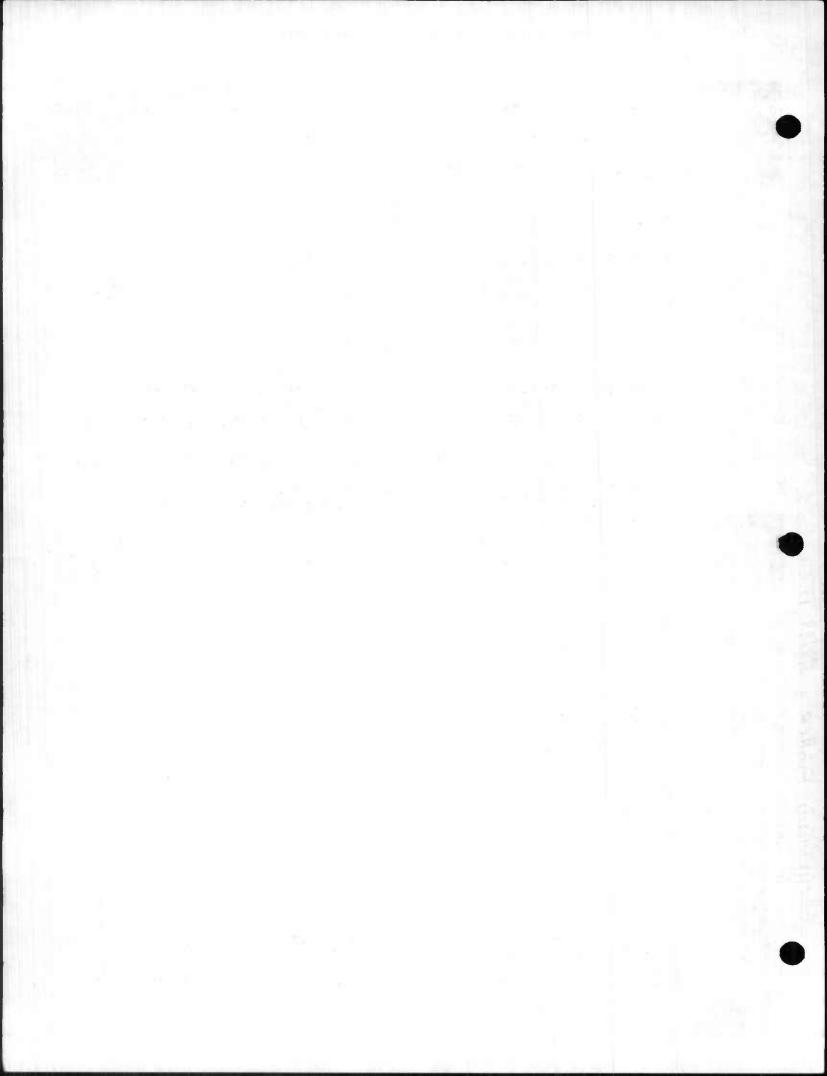


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/Medic	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea	Day	3. Time of Deeth
	ai	DORA	FINE			th City Town or	March	5 199	
Examin		4e. Facility Name (If not Institution, give BROOKE GROUE REHABI	The second secon	~ N1. 105.	No CENTRA	SANDY S			
unerai		5. Social Security Number 6. S		(In yrs. last b	irthday) If Under 1 Y	ear If Under 24 Hrs			9. Birtholace (State or Foreign
irector		070.42.9123 Usuel Residence of Decedent	□M 2√2 F	97	Yrs. Months Da	ys Hours Min	8. Date of Birt (Month, De 05.01.		Birthplace (State or Foreig Country)     RUSSIA
MOW IN		10e. State 10b. County		10c. City, Tov	vn or Location				10d. Inside City Limit
alf fee	ctor	MARYLAND MONTGOM	MERY	SANDY	SPRING				1 ☐ Yes 2 📉 No
23a or 2	Funeral Director	10e. Street and Number 18432 BROOKE GROV	VE ROAD		10f. Zip Coo 208			10g. Citizen of Wi USA	nat Country?
al', o	P	11. Marital Stetus  1 Never Married 2 Married  3 Swidowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Detes:		13. Was Decedent If Yes, specify 0 1 ☐ Yes 2 2	of Hispanic Origin? (S Cuban, Mexican, Puer No <i>Specify</i> :	Specify Yes or No- to Ricen, etc.)	14. Race Black Specify:	- American Indian, , White, etc.
"natural", epical Exe	ted	15. Decadent's Ed (Specify only highest gra	lucation	168	Decedent's Usuel Oc	cupation	artein a	16b. Kind of Bus	
200	Completed	Elementery/Secondary (0-12)	College (1-4or 5	+)	iife. DO NOT use re	ne during most of wo tired)	rking	0171 110	
other than		b		1	IOMEMAKER	T		OWN HO	
p A	o Be	17. Father's Name (First, Middle, Last) DAVID COHN					me (First, Middle, A "UNKNO		)
7 la marked traumatic ev	ř	19a. Informant's Name/Relationship (7	Type Print)	19	h Mailing Address (Str	eet and Number or B	ura / Poute Numbe	or City or Town S	itete, Zip Code) 20906
		HELEN OSHEROFF/DA							SPRING, MD
Item 27 other tra		20a. Method of Disposition		20b. Place	of Disposition (Name ory, crematory or other	,	Date		ity or Town, Stete
Important: If Ite any Injury or of once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion ▲ ☐ Other (Specify			OMFORT CRE		3.8.99	AT.EYAND	RIA, VIRGINIA
Paris Se Se		21 can sture Fernera Service Liven	see	01		dress of Fecility AGEL FUNE			
any li		Marken -	-	ΧI		KVILLE PI			
	1	23a. Lint. Enter the disease, or composite of heart failure. List only of	plications that caused	the death Oo	not enter the mode of				Approximate
ician		distance List only to	one cause on each line	/)					Intervat Between Onset and Deeth
edicai miner		Immediate Cause Final disease	. ACUTE	od da	- FAILUR	F			DAYS
		resulting in death)	4.		consequence of):		· · - · - · - · - · - · - · · · · · · ·		
sit .	Examiner		b. DEHYD	RATIO					DAYS
physician and the buriel-transit	xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		and the inter-	consequenca of):				
		Cause. Enter Underlying Cause (Disease or Injury that initiated events	· REFUSA						2 WEEKS
0 6	Medical	resulting in death) Last	d	oe to (or as a	consequence of):				
ed by the attendin deteched for use	Physician/M								
by the	hys	Part II. Other significant conditions co					450		ribute to the cause of death
be det	by P	CONGESTIVE +	teart f	AILU	RE; HYP	ERTENSIC	יין יין	es 2⊠(No 3	B Probably 4 Unknow
s been sig	Completed	ATRIAL FIB	RILLAMO	۷			24a. Was a	an eutopsy med?	24b. Were autopsy findings available prior to completion of ceuse of death?
age 2	E						101	es 2K No	1 ☐ Yes 2 ☐ No
		25. Was case referred to medical				26. Place of De	ath (Check only o		
al direc	0	examiner?	Hospital: 1 ☐ Inpatien	t 2 ER/O	utpetient 3 DOA	Other	fome 5 ☐ Resid		(Specify)
3 (00		27. Manner of Death  1.⊠Naturel 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury (Month, Day			njury at Vork? □ Yes 2 □ No		ow injury occurred	
n by t	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injur building, etc.	y - At home, fa (Specify)	ırm, street, factory, offi	ca	28f. Location (S City or Tow		or Rural Route Number,
8 6		29a. Certifier (Check only one) 1 Certifying Phy	sician: To the best of iner: On the basis of e and manner state	xemination ar	e, death occurred at the d/or investigation, in m	time, date and plece y opinton, death occu	e, and due to the corred at the time, o	ause(s) and menr late and ptace, an	ner as stated. d due to the cause(s)
pletely filled I	0	non-Circums and title of and title			111111111111111111111111111111111111111	ense number			(Month, Day, Year)
To the Funeral Direct completely filled in by	-	29b. Signature and title of certifier							
completely filled I	Σ		STARE PHY	SICIAN	DL	12041	1	larch 5	1 1999
To the Funeral D	Σ		STARE PHY	SICIAN ath (Item 23a)	(Type, Print)	12046	1	larch 5	1, 1999
To the Funeral Director: Atter completely filled in by the funer	2	30. Name and address of person who co	STARE PHY ompteted cause of dea UFFMAN, L 32. Registrar	SICIAN ath (Item 23a) LD. 181	(Type, Print)  OO Slade S	t 2046 school Road	Sardy S	bering. H	1999 anyland 2086

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					State	of Marylar				lealth and i Death		giene 9 9 Reg. No.	0	9   5	6
		Dhusia	ion	1. Decedant's Nama (First, Middla, Last	)				10		2. Data of Da Month	ath Day	Yaar	3. Tima o	of Death
		Physic /Medi		MILDRED	FIS	HER					MARCH		99	6:5	2PM
		Exami	ner	4e. Facility Nema (If not Institution, give		umber)				4b. City, Town, or		,			
			, a	SUBURBAN HOSPI				Killader	1 Vans	BETHESI			GOME		
		Funeral Director		5. Social Sacurity Number 6. Sa 577 34 4255 Usual Rasidance of Dacedent	M SEENE	7. Aga (In yrs.		If Under Months	Days	Hours Min.	8. Data of Bir (Month, Da DEC 21	y, Year)	9. Birthpi Coun GA	lace (Stata try)	or Foreign
		show		10a. Stata 10b. County		10c. Ci	ty, Town or Lo	cation					16	Od. Inside C	City Limits
		r 28a-f show	ţō	D.C.		To To	ASHIN	GTON						Yas	s 2 No
		vith the	Funeral Director	10e. Street end Number				10f. Zip	Code			10g. Citizen of \	What Coun	try?	
		23a	a	3635 13th ST.,	N.W.				2	20010		U	SA		
		hems hems	nue		Armed F		,S. 13. V	Was Deced	ent of H	lispanic Origin? (S an, Maxicen, Puert	pecify Yes or No o Ricen, atc.)	14. Rec Bled	e - Amarica ck, Whita, a		
	20	, or h	by F	1 Never Married 2 Marriad  3 ☑ Widowed 4 Divorced	1 ☐ Yes If Yas, G Year or I	2⊠ No iva		1□ Yas 2	No X	Specify:		Specify	BL	ACK	
	9	"natural",	ed t	15. Decedant's Edu		Jates.	16a. Deced	ient's Usua	I Occur	pation		16b. Kind of Bi	usiness/ind	lustry	
	21215-0020	hin 72	piet	(Specify only highest gred Etementery/Secondery (0-12)	a complated,	) (1-4or 5+)	(Give	kind of wor DO NOT us	rk dona se ratires	during most of word)	rking			,	
		filed within 72 hours after death with the Maryland Hygiena. other than "natural", or items 23s or 28s—f show ent, it a Medical Examiner must be notified at	Completed	12	Conago	(1 40.01)	Н	OUSE	WIF	E		n/	a		
	pur	be filed ital Hyg d other event,	Be	17. Fathar's Nama (First, Middla, Last)						18. Mothar's Nar	na (First, Middle,	Maidan Surnam	na)		
	7	d Man	2	CHARLIE E. S			T				E B. W				
	Maryland	s 1 and 2 should be filed if Health and Mantal Hygic Item 27 Ia marked other other traumatic event, II		19a. Informant's Name/Relationship (Ty BARBARA WRIGHT/		ITER		-		ond Number or Ru					
		of Healt Item 2 other		20a. Mathod of Disposition		20b. F	Place of Dispos	sition (Nan	na of		Date	20c. Location -			
	Baltimore,	permit. Pages 1 Department of H Important: If Itel any injury or ott		1 Bunal 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lamovel from	Steta	cemete <i>ry, cr</i> an REENHI				3/99	COLUMB			
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1		_		23a. Part1. Enter the disease, or complishock, or heart faiture. List only or	cations that	caused the deat	h. Do not ente	3435 er the mod	e of dylr	th ST.,	or respiratory e	20010 rest,		Approxime	ite
		Physician		shook, or report rational class only or									1	Onsat end	Death
2	7	/Medical Examiner	и	Immadiata Causa (Final disaasa or condition	a	Thero	reler	the	1	read or	crear			yea	w
S		Lxummer	-	resulting in death)			or as a conseq							1	
00		ped nsit	Examiner		)								1		
~	oʻ.	axecu n and ial-tra	Exa	Sequentially list conditions, if any, leeding to immediata		Dua to (d	or as a conseq	uance of):							
199	8760,	requires that the death certificate be assocuted seen signed by the attending physician and hould be datached for use as the bunal-transit	dicail												
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3	30X	aath certific attending p for use as	an		1										
	0.	a dae the at hed fo	Physician/Me	Part II. Other significent conditions con	tributing to d	leath but not res	ulting in tha ur	ndarlying ca	ause giv	ran In Pert i.	23b. Dld	obacco use co	ntributa to	the cause	of death?
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		Hospital     24 hours a     Funeral E     Hetely filled	edicai	29a. Cartifiar (Check only one) Certifying Physical Examination (Check only one)	er: On that	a best of my kno easis of axemine nnar stated.	wiedge, daath tion and/or inv	astigation,	In my o	ne, date end plece pinion, daath occu	, end dua to tha rred at tha tima,	causa(s) and me data and place,	and dua to	ated. tha causa(	s)
		To the Hospital or At within 24 hours after of to the Funeral Direct completely filled in by	M	29b. Signeture end title of certifier	/					a number		29d. Data signe			
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		_3		30. Number and address of person who co				Print)		L			1 1.	40	
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		Registr	ar	MAD 1 1 199	19	The same	N.	100	MULK	2					



complately To the I 6

> State Registrar

Stephen Radentz 31. Data filed (Month, Day, Year) MAR 0 9 1999

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

29b. Signatura and titla of certifiar

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signatura senera

29c. Licansa number

OCME

29d. Data signed (Month, Day, Year) MARCH 03, 1999



State of

Maryland / Department of Health and Mer	ntal Hygiene	09158
Certificate of Death	Reg. No.	03100

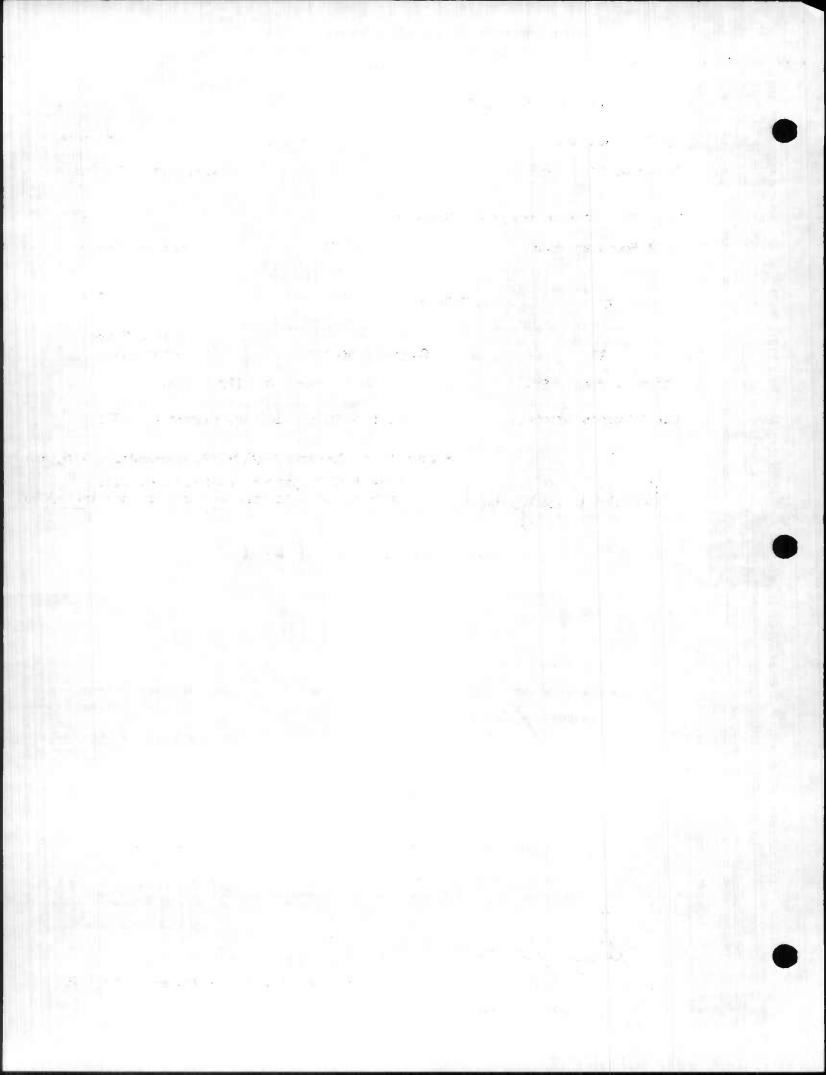
Dromett	Freas, Jr.	(	Certificate of	Death	R	eg. No.	03130
Dhusisian	Decedent's Name (First, Middle, Last)				2. Dete of Daat Month	Day	3. Tima of Death Year
Physician /Medical	Alan D. Freas, Jr	•			March (	7	
Examiner	4a Facility Nama (If not institution, give street and number)			4b. City, Town, or Lo		4c. County	
	2A Southway Road  5. Social Security Number 6. Sax 7. Aga //	n yrs. last birth	day) If Under 1 Year	Greenbel If Under 24 Hrs.			e George's
Funeral Director	393–32–4613 XXM 2□ F	63 Y	Months Davs	Hours Min.	8. Data of Birth (Month, Day, Oct • 22	1935	9. Birthplaca (Stata or Foreign Country) Wisconsin
and and	Usual Rasidance of Decedant  10e. Stata 10b. County 10	Oc. City, Town	or Location				10d. Inside City Limits
r 28a-f ahow	Maryland Prince George's	Greenb	elt				Yas 2□No
th with the Ma 23a or 28a-fa 21be notife al Director	10e. Street and Number 2A Southway Road		10f. Zip Coda 20770		1	og. Citizan of V United	What Country? States
or items	11. Marital Status  1 Never Married 2 Married  3 Widowed XXDivorced  12. Wes Decedant Event Armed Forces?  12. Wes Decedant Event Armed Forces?  13. Widowed XXDivorced  14. Wes Decedant Event Armed Forces?  15. Was a 2 No If Yas, Giva Yaar or Detas: 19		13. Was Decedant of If Yas, specify Cub		ecify Yes or No- Rican, atc.)	Blad	e - American Indian, ck, Whita, atc. :: White
"natural".		16a. C	ecedant's Usual Occu	pation		16b. Kind of B	usinass/Industry
led within 72 ho lygiene. Ser than "natura N, the Wedgell Completed	(Specify only highast grada complatad)  Elamentary/Secondary (0-12) Collega (1-4or 5+)	- 1	Decedant's Usual Occu Giva kind of work dona ifa. DO NOT usa ratira	ad)	ing	United	States
giene The The	12 2	Con	puter Anal	*		Govern	
Mental Hy arked other atic event.	17. Fetner's Nama (First, Middle, Last)			18. Mothar's Name Ruth Est			ne)
permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is merked other than any injury or other traumatic event, the Mannes.  To Be Compl	19a. Informant's Name/Relationship (Type, Print) Carol Kussow (sister)		Malling Addrass (Street 13 Todd Dr				Stata, Zip Coda) 53713
f Hear tem	20a. Mathod of Disposition	20b. Place of E	Disposition (Name of cramatory or other pla	aca)	Deta	20c. Location -	City or Town, Stete
y or ™	1 ☐ Buriat 2 🛣 Crametion 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify)				10/1999	Alexan	dria, Virginia
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the de	Part II. Other significant conditions contributing to death but r	not rasulting in	tha undarlying ceusa g	ivan in Part I.			ontribute to the cause of death
that the ed by deta	Cancer of Laryn,	X			101	/es 2□ No	3 ☐ Probably 4 ☑ Unknow
To the Hospital or Attending Physician: The lew requires that the death certi within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the attending completely filled in by the funeral director, page 2 should be detached for use Medical Certification: To Be Completed by Physician/M						an autopsy med?	24b. Wara autopsy findings available prior to completion of ceuse of death?
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• Hospit • Funera • Funera • Funera • Funera • Funera	29a. Cartifiar (Check only one) 1 ☐ Cartifying Physician; To the best of manual states of average of the control of the best of a card manual states of average of the control of the best of the best of the control of the best of the control of the best of the control of the best o	ny knowledga, kamination and	death occurred at the	tima, data and place, opinion, daath occur	and dua to tha d	causa(s) and m	annar as stated.
To the To the Comp	29b. Signatura end title of cartifiar			nsa number			ed (Month, Day, Year)
12	W. Allet		0	.C.M.E.		March	8, 1999
	30. Nama and addrass of person who complated causa of daal	th (Item 23a) (1	Type, Print)				
	Dennis J Chutero			Street, E	Baltimor	e, Mary	land 21201
						-	

State Registrar

Denns J. M. 31. Data filed (Month, Day, Year)
MAR 1 1 1999

32 Registrar's Signatura

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene

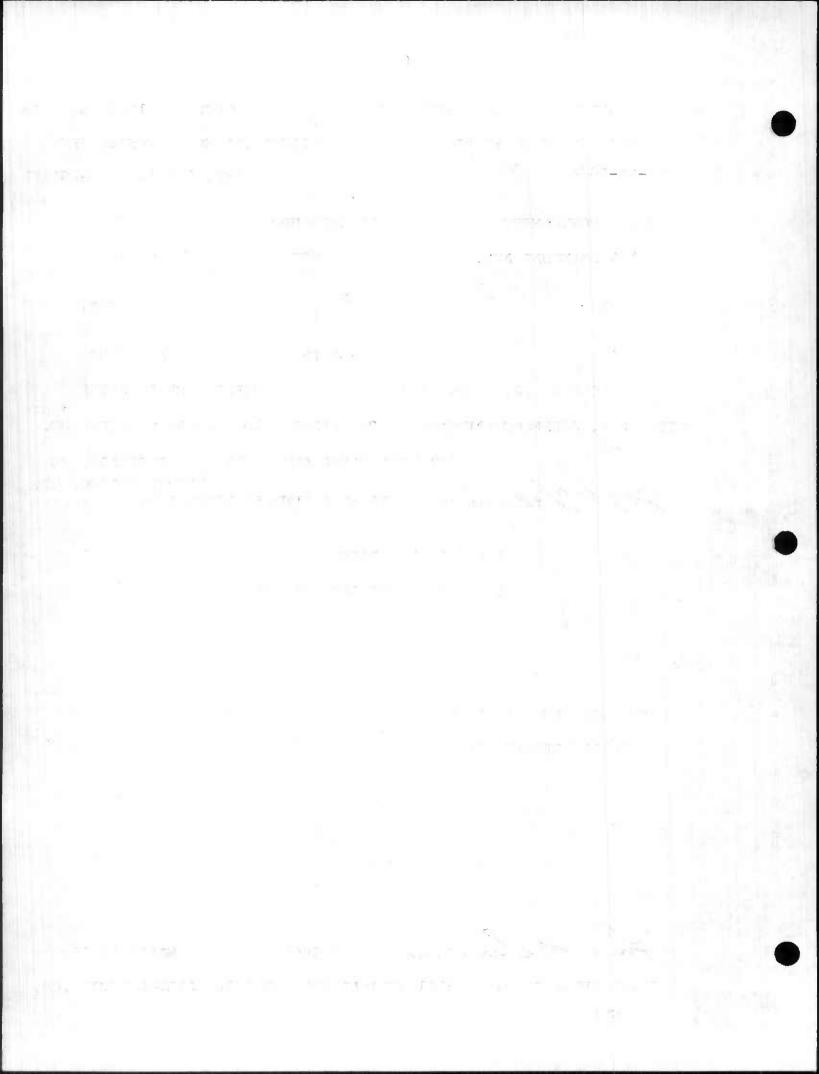
Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month Yaar MILDRED FULLWOOD 1999 MARCH 5:35 PM /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b City Town or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Undar 1 Yaar 5. Social Sacurity Number If Undar 24 Hrs. Birthplaca (Stata or Foraign Country) 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** 10 M 20 F Days Yrs. 239-36-5658 87 Director FEB.10,1912 N. CAROLINA Usuai Rasidance of Dacadant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show items 23a or 28a-f shoving must be notified at 1 □Yas 2 □ No Director MONTGOMERY MD. GAITHERSBURG 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ODENDHAL AVE. 101 20877 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No It Yas, Give Yaar or Datas: 11. Marital Status 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. The Medical Exerviner filed within 72 hours aftar 1 ☐ Naver Marriad 2 ☐ Married 21215-0020 ò 1 ☐ Yas 2 No Specify: by Specify. 3 ☐ Widowad 4 N Divorced "natural", WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadent's Education 16b. Kind of Businass/Industry (Spacify only highast grada completed) I Hygiana. Elementery/Secondary (0-12) Collega (1-4or 5+) 11 HOMEMAKER AT HOME 7 is marked other traumatic event. Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Pages 1 end 2 should be fill mant of Health and Mentel Hant: If Item 27 is marked out Be ROBERT THOMPSON J. NELLIE CARL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) MILDRED F. JOHANSON/DAUGHTER other 19703 FRAMINGHAM DR., GAITHERSBURG, MD. 20b. Placa of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata permit. Pagas Department of Important: If It any injury or o 1 ☐ Buriai 2 🏋 Cramatlon 3 ☐ Ramovai from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) CHAMBERS CREMATORY 3/11/99 RIVERDALE, MD. 21. Signatura of Funaral Sarvica Licensea 22. Nama and Addrass of Facility SILVER SPRING, MD. rangeled M00091 CHAMBERS FUNERAL HOMES, P.A. 23a. Part1. Entar tha disaasa, or complications that causad the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween **Physician** Onsat and Daath /Medicai Immediata Causa (Final RESPIRATORY FAILURE 1 WK disaesa or condition resulting in daath) Examiner Dua to (or as a consaquence of): Examiner NON SMALL CELL LUNG CANCER 2 YRS The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undartying Ceuse (Disaasa or injury that initiated evants rasulting in daath) Last Dua to (or as a consequanca of): P.O. Box 68760, physician Physician/Medical the Dua to (or as a consequanca of): signed by tha a Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown CHRONIC LUNG DISEASE Division of Vital Records, à 24b. Were autopsy findings aveileble prior to complation of causa of death? Completed 24a. Was an autopsy performed? CORONARY ARTERY DISEASE 1 Tas 2 X No 1 ☐ Yas 2 ☐ No the Hospital or Attending Physician: Be 25. Was casa refarred to medical axaminar? 26. Placa of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital: 2 1 ☐ Yas 2 X No 1 XInpatiant 2 ER/Outpatient 3 DOA this 27. Mannar of Deeth 1 Netural Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how Injury occurred Medical Certification: 28c. Injury at Work? Aftar 5 Panding Invastigation daath. 1 ☐ Yas 2 ☐ No 2 Accidant aftar daath 6 Could not be datarmined 3 Suicida in by t 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida within 24 hours a

To the Funeral D

completely filled 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or invastigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifian (Check only one) 29b. Signatura and title of certifian 29c. Licansa number 29d. Data signad (Month, Day, Year) noc. D35996 MARCH 10, 1999 30. Nama and addrass of person who complated cause of deeth (itam 23e) (Type, Print) LINDA BURRELL, MEDICAL PARK DR. #210 , SILVER SPRING, MD. M.D. 2101 32. Registrar's Signatura 31. Data filad (Month, Day, Year) State Registrar MAR 1 1 1999

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 2. Data of Death Month March 9, 1999 4b. City, Town, or Location of Death 4c. County of Death

1. Decedent's Nama (First, Middla, Last) 3. Tima of Death **Physician** Adelaide H. Furman 1:00 AM /Medical 4a Facility Nama (If not institution, giva street and number) Examiner Prince George's Hospital Center Prince George's Cheverly If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 6. Sax Birthplaca (Stata or Foraign Country) **Funeral** 1 ☐ M 2 💢 F Months Days Hours Yrs. Director 215-36-3800 Sept. 15, 1907 Pennsylvania Usual Rasidance of Dacedant permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Depertment of Heath and Mental Hygiene. Inmoortant: If term 27 is marked other than "patural", or items 23a or 28a-f show any injury or other traumatic event, in a Medical Example must be notified at 10a. Stata 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Directo Mitchellville Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 10450 Lottsford Road, Apt. 116 20721 Funeral United States 12. Was Decedant Evar in U.S. Armed Forcas? 1 ☐ Yas ≥ ☑ No if Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian. Black, Whita, atc. 1 ☐ Navar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify p 3 N Widowed 4 □ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Cotlega (1-4or 5+) 5+ Own Home Homemaker 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be Margaret Romine Alexander Henry Holcombe 19a. Informant's Name/Raiationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) William A. Furman, III / son P.O. Box 1769, Venice, California 90291 20b. Placa of Disposition (Nama of cematary, cramatory or other place) March 10, 1999 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 A Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signatura of Funaral Sarvice Licensage 22. Nama and Addrass of Facility M00831 Smon Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Julian dawnence 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the lisaasa, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Death Physician Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disease or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) for use as signed by the aid be deteched for 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to complation of cause of death? should I 24a. Was an autopsy performed? Completed page 2 s hes 1 Yas 2 No 1 ☐ Yas 2 No certificate Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica funeral director, 25. Was casa rafarred to medical axaminar? Be 26. Placa of Daath (Check only ona) 1 Yas 2 No Hospital: → Inpatiant 2 ER/Outpatient 3 DOA Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify) Certification: To 27. Mannar of Daath 28a. Data of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how tnjury occurred 28b. Tima of 1 Natural 5 Panding 1 ☐ Yas 2 No invastigation 2 Accidant 3 Suicida 6 Could not be datamined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 ☐ Homicida • Funeral C 🔀 Certifying Phyelcian: To tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 29a. Certifian Medical completely 2 Medical Examiner: On the basis of axamination and/or trivastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mariner stated. within 2 To the ş 29c. Licansa number 29b. Signature and title of certific 29d. Data signad (Month, Day, Year) 2 30. Nama and addrass of person who complated cause of death (itam 23a) (Type, Print) William F. DuBoyce, M.D. 79 Kettering Drive, Upper Marlboro, MD

DHMH 16 Rav 6/95

State

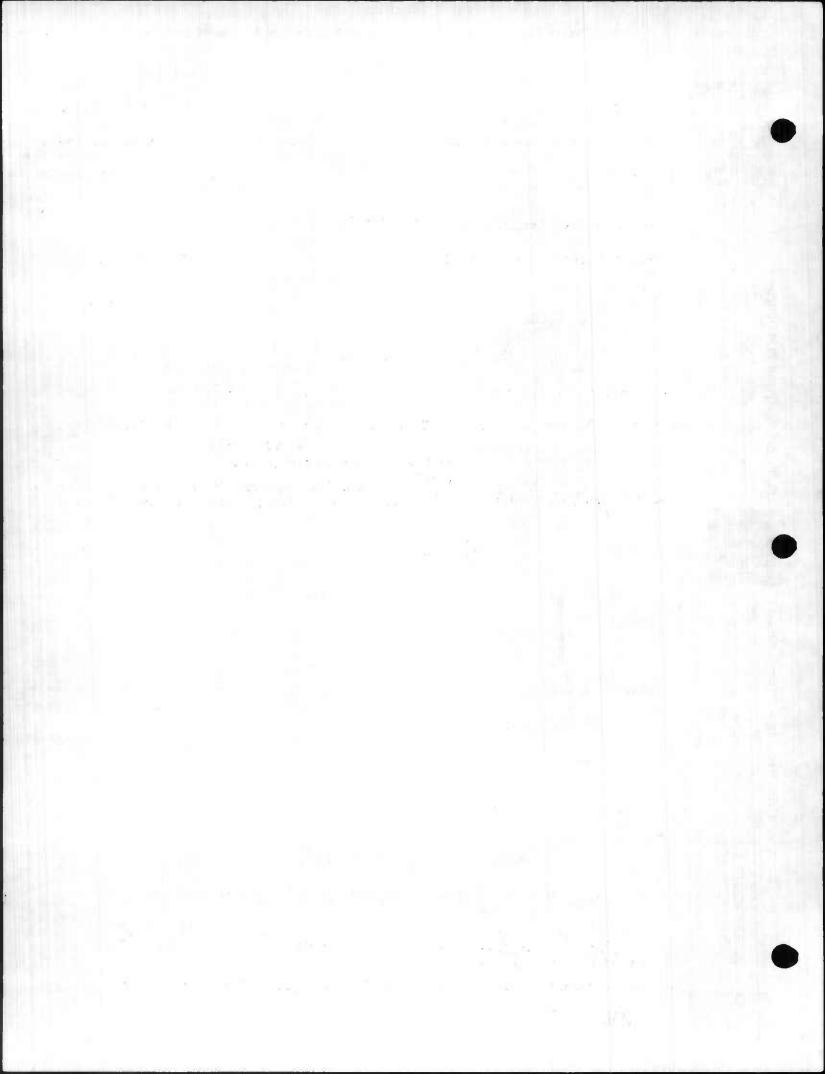
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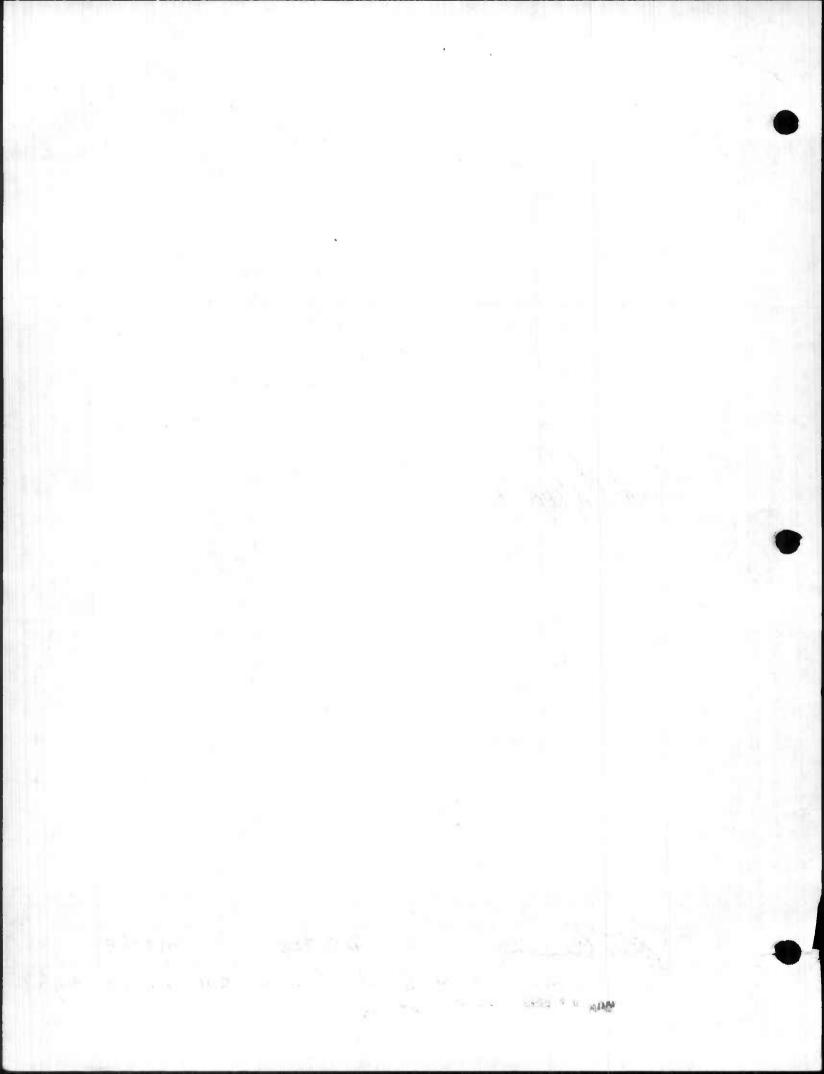
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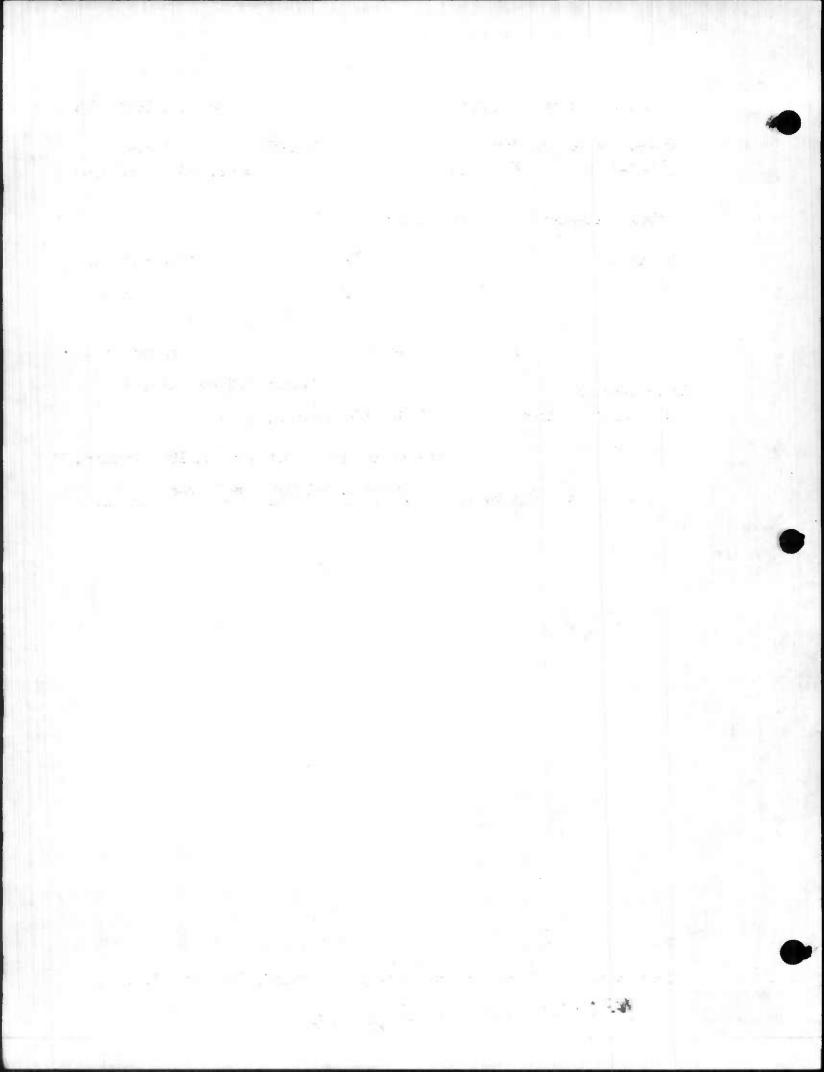
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State of Maryland / Department of Health and Mental Hygiene 9

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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						tificate of	f Death		Reg. No.	UJ	100
	Physic	ian	1. Decedent's Name (First, Middle, La	est)				2. Dete of De Month	eth Day	Yeer	3. Time of Deeth
Л	/Medi	cal	GEORGE 4e. Fecility Neme (If not institution, gir	D.		FI	4b. City, Town, or L	MARCH costion of Death		1999	2:35 AM
f	Exami Funeral Director	ner	5. Social Security Number S. I. N.		CTR vrs. lest birthdey) Yrs.	if Under 1 Yea Months Day	BERLIN ar Ir Under 24 Hrs.	8. Date of Bir	Work	CESTI	E R ace (State or Foreign y)
	pu ×		Usuel Residence of Decedent 10e. State 10b. County	10c	City, Town or Lo	cation				T10	d. Inside City Limits
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	or 188	irec	10e. Street end Number			10f. Zip Code			10g. Citizen of	Whet Countr	y?
	23a c	raid	5 SASSAFRAS LA	NE			21811			USA	
020	n 72 hours elter death with the Maryland "natural", or items 23a or 28a-f show solgal Examiner must be notitled at	by Funeral Director	11. Marital Status  1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1/5 Yes 2 □ No if Yes, Give Year or Dates:		Vas Decedent of Yes, specify Cu ☐ Yes 2 (A)	Hispenic Origin? (S) ben, Mexican, Puerto o Specify:	pecify Yes or No Pican, etc.)	14. Rad Ble Specify	ce - America ck, White, el	tc.
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ylar	should be filed end Mentel Hygi is markad other aumatic event, i	To B	ANDREW J. FIED	LER			OTILL	IA C.	WEIGAN	ID	
Maryland	2 8 8		19a. Informent's Name/Relationship	Type, Print)	19b. Mailin	g Address (Stree	et and Number or Ru	rel Route Numb	er, City or Town,		
Baltimore, I	ges 1 en t of Heeli If Item 2 or other		MARY D. FIEDLER 20a. Method of Disposition Buriel 2 Cremetion 3 D	Removel from State		netory or other pi	lace)	Dete	PINES, 20c. Location	City or Tow	m, Stete
altin	Semit. Pa Sepertmen mportant: any injury		4 ☐ Donetion 5 ☐ Other (Special Signeture of Fundal Service Lice			RANS C Name end Add	EMETERY ress of Fecility	3-12	HURLOC	: K ,   M :	D.
m	205.0		Dehit 1	Mex	UL	LRICH	FUNERAL	HOME	BERLIN	, MD	
			23a. Enter the disease, or coff	plications thet caused the done cause on each line.	eeth. Do not ente	er the mode of dy	ying, such es cardiec	or respiretory e	rrest,		Approximate Intervel Between
	Physician /Medical Examiner		immediete Ceuse (Final diseese or condition resulting in deeth)	e. Con	GUS a	Tive,	HEAR	HS FA	16 Ur		Donset and Death
Box 68760,	eeth certificete be executed attending physician end I for use es the buriel-transit	Physician/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events resulting in death) Last	b. CORU	o (or es e consequence of the co	Property:	Ante	111010	Jeno.	1/5	Jey
	it the deet by the attri	sicle	Pert II. Other significent conditions of	ontributing to death but not	resulting in the un	derlying ceuse g	given in Pert I.	23b. Did	tobacco uee co	ntribute to t	the cause of death?
P.0	that the		Pan pho	110 Va	164/2	h h	1scmse	10	Yee 2□ No	3 Probe	bly 4 Unknown
Records,	requires been sign should be	Completed by	of abou	1 1 Va	B	200	LA G	24e. Wes	en eutopsy omied?	evail	e eutopsy findings leble prior to pletion of cause seth?
	The lew ste hes b page 2 s	ome						10	Yes Z No		Yes No
/ita	yslcian: The	Bec	25. Was cese referred to medical exeminer?				28. Place of Dee	th (Check only o	one)		
of	Physic this or ral dire	-T	1 ☐ Yes 2 ☐ No  27. Manner of Deeth		ER/Outpatient	3LI DOA			dence 6 □Oth		
ion	Attending Physician: ir death. sctor: After this certific by the funeral director,	ation	14 Neturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju W	ork? □ Yes 2 □ No	28d. Describe	how injury occur	rea	
Division of Vital		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - A building, etc. (Spe	t home, ferm, stre	et, factory, office	9	28f. Location (S City or Tox	Street and Numb wn, Stete)	oer or Rural i	Route Number,
	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	edical	one) 2   Medical Exam	yalclan: To the best of my k niner: On the basis of exami end menner steted.	nowledge, death ination end/or invi	estigetion, in my	opinion, deeth occur	red et the time,	date and plece,	and due to t	he cause(s)
	within To the comple	Σ	29b. Signeture end title of certifier				nse number		29d. Date signe	d (Month, D	ey, Year)
			20 Nome and address of		)		2026		019	161	
			30. Neme and eddress of person who FEDERICO ARTHI 31. Date filed (Month Day Year)		EAL CIRC		EAN PINES	, MD 218	811		

State Registrar 32. Régistrer's Signeture 9. Aparts

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Clearth Fisher Month 1814 3, 1795 4c. County of Death 3 Mouch 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, Year) 33 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□M 20 F Yrs. Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Accomack (hinco teague Virginia 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7203 Fisher Drive U. S. A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Biack, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 I No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Sell Homemaker 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Boothe Hilliany Bloxom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code) 335 Barry E. Fisher Husband 20b. Place of Disposition (Name of cometery, crematory or other place)
John Taylor Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 3-7-99 Temperanceville, 21. Signature of Funeral Servica Licensee 27 Name and Adhess of Facility Home (hinco teague, Virginia 23336 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCUD 24 hours disease or condition resulting in death) Due to (or as a consequenca of): Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequenca of): Due to (or as a consequenca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown high Cholesterol 24b. Were autopsy findings available prior to 24a. Was an autopsy periormed? completion of cause of death? 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piaca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed ettending physiclan After this certificate has been signed by the the Hospital or Attending Physician: Director: After this in by the funeral death.

Physician/Medical Medical Certification:

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

or items 23a or 28a-f show

Funeral Director

by

Completed

Be

2

traumatic event, the Medical Exerciner must be notified at

the Maryland

filed within 72 hours after death with Hygiene.

permit. Pages 1 and 2 should be filed within 72 hours Deperment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, its Medical Exponen.

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

Shirley Fraher

þ Completed Be 2

29a. Certifier

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier

29c. License number H5049) 29d. Date signed (Month, Day, Year)

313199

Chris Snyder D.O. DME

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Pine Bluff 108

Salis buy 32 Registrar's Signature

souls

State

Registrar

within 24 hours e To the Funeral C completely filled

Time Plan Plan le og i tig tig tig tig 10/19/1 12: 01 وروجون والمتلاوا ومعادداتها 

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State of Maryland / Department of Health and Mental Hygiene

Funeral Director	Sally T.  4a Fecility Name (If not institution, 313 Colony Poir 5. Social Security Number 154–22–1229  Usual Residence of Decadent	t Place						March	6, <sup>D</sup> 1999	9 Year	2:30PM
Funeral Director	313 Colony Poir 5. Social Security Number 154-22-1220	t Place						-Non of Deal	h		
Director	154-22-1220	S Sex 7 Age /				Edge	ewate		Anne	e Aru	
Sa-f ahow purad at	Usual Residence of Decadent	1□M 2MF 67	In yrs. last birthda Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bi (Month, D June	th ey, Year) +, 1931	9. Birth Cou Phila	place (State or For intry) adelphia,
Sa-f ah	10a. State 10b. County	1	Oc. City, Town or	Location							10d. Inside City Lin
00 H X	Maryland Anne A	rundel	Edgew	ater							1 ☐ Yes 2 💆
3a or 2 at be no	10e. Street and Number 313 Colony Poir	nt Place		10f. Zi	p Code	210	37		10g. Citizen o	f What Cou	USA
tal Hygiene. d other than "natural", or Nems 23a or 28a-fa event, the Medical Essavina; must be notified event, the Medical Essavina; must be notified. Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorcad	12. Wes Decedent Ev. Armed Forces?  1  Yes 2 No if Yes, Give Year or Dates:	er in U,S. 13	3. Was Dece if Yes, spe 1 \( \text{Yes} \)	ecify Cub	Hispanic On an, Mexicar Specify:	gin? (Spec n, Puerto F	city Yes or N lican, etc.)	8	aca - Ameriack, White	
natur	15. Decedent's (Specify only highest	Education grade completed)	(Gi	cedent's Usi	ork done	dunna mos	t of workin	g	16b. Kind of	Business/li	ndustry
than the Ma	Elementary/Secondary (0-12)	4 College (1-4or 5+)		cher	use retire	(d)			P.G. C	O. Sci	hool Syst
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Department of Health and Menta Important: If Nem 27 is marked any injury or other traumatic entire.  To E	19a. informant's Name/Relationsh Kevin W. Fuhrman								Der, City or Tow MD. 211		ip Code)
nt: if them ry or othe	20e. Method of Disposition  1 □ Burial 2 □ Cremetion  4 □ Donation 5 □ Other (Sp.	3 ☐Removel from State	20b. Place of Dis cemetery, c Metropol	position (Na remetory or itan	me of other pie Crem	atory	3/	Date /8/99	20c. Location		
Departm Importa any inju pnce.	21. Signature of Funeral Service L	censee							ome, P.		. 21037
	23a. Pert f. Enter the disease, or o shock, or heart failure. List of	omplicet his that caused the	e death. Do not e	enter the mo	de of dyi	ng, such es	cardiac or	respiratory	arrest,	er, rib	Approximete Intervel Between Onset and Death
nysician Medical xaminer	Immediate Cause (Final disease or condition resulting in death)	Acute M	lyeloid I	Leukem	ia					1	1 yr.
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within 24 hours after deatl To the Funeral Director: completely filled in by the Medical Certifical		Physician: To the best of examiner: On the basis of examiner state	camination and/or								
To the comple	29b. Signeture end title of continu	Have	~	29		se number	1		29d. Date sig		, Dey, Year) 1999
	30. Name and address of person w		th (Item 23a) (Type	pe, Print)		-		RAI	T. MD	~ 4/	67

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				State of Ma	arylar		oartmen ertificate				giene 9	091	66
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b	Exami		4a. Facility Name (If not institution, given	re street end number)					4b. City, Town, or	Location of Deet	h 4c. County	of Deeth	
1			IRVINGTON KNOLL	CARE CENTE	R				CATONS	SVILLE	J	BALTIMOR	E
	Funeral Director		5. Social Security Number 6. S 207-12-3500	Sex 7. Ag I□M 2ਊ F	e (In yrs. 77	lest birthde Yrs.	Months	1 Yeer Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De		9. Birthplece (Country) PENNSYL	Stete or Foreign
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	for death with the Marylan items 23a or 28a-f show	ral Director	10e. Street end Number 1027 MILLERS CIR	CLE			10f. Zip	Code 210:	32		10g. Citizan of	Whet Country?	
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O	ing Affei fune	tlon	1 ØNaturel 5 ☐ Pending 2 ☐ Accident Investigation	28e. Date of Injui (Month, De)	Year)	28b. Time Injury	M Z	Bc. Injur Wor 1 □	y et k? Yes 2 □ No	28d. Describe	how Injury occur	төд	
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Registrar

State

31. Dete filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedant's Neme (First, Middla, Last) Month **Physician** Marie Fazenbaker 05:50 AM March 8, 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street end number) Examiner Garrett County Memorial Hospital Garrett Oakland If Undar 1 Yaar | if Under 24 Hrs Birthpiaca (Sfefa or Foraign
Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 1□ M 2 F Deys Hours Min Yrs 217-05-0391 88 **Director** June 10, 1910 Maryland Usual Rasidance of Decedant with the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. fnside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Md **Allegany** Westernport TXXYas 2 No Director 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 406 Walnut St. 21562 United States permit. Pages 1 end 2 should be filed within 72 hours efter deeth v Department of Health end Mental Hygiene. Important: if Itam 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examinat mantal ends. Funeral 14. Race - American Indian, Black, Whita, atc. 12. Wes Decedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11 Marital Status 1 Yas 2 No
If Yas, Giva
Yaar or Datas: 1 Navar Marriad 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Induatry 15. Decedant's Education (Specify only highest grada complated) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Homemaker Home 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Luke Kearney Olive Boyce 19a. Informant's Nama/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Marian Sparaco / Niece 477 Taft Ave. Barberton, Ohio 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 3/10/99 Cumberland, MD Cumberland Crematory 21. Signature of Funerei Service Licensae 22. Nama and Addrass of Facility 111 Church Street Re Westernport, MD 21562 Boal Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarvai Batween Onsat and Death Physician /Medical Immediata Ceuse (Final disaasa or condition resulting in deeth) atherosclerotic cardiovascular disease l hour Examiner Due to (or as a consequence of): Examiner the death certificete be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury Due to (or es e consequence of): physician e P.O. Box 68760, Physician/Medical that initiated avants resulting in deeth) Last Dua to (or as a consequance of) 88 950 for signed by the a Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No. 3 Probably W Unknown diabetes mellitus Records, by lew requires 24b. Ware autopsy findings available prior to completion of cause of death? bloods Completed 24a. Was an autopsy ate hes 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director, 25. Was casa rafarred to medical examinar? Be 26. Placa of Death (Check only one) Hospitai: Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 2 1 ☐ Yas 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mannar of Death 28c. Injury at Work? 28b. Tima of Certification: After 1 (XNatural A hours after deserved hours after deserved Director. After the further forms and the 5 Panding invastigation 1 Yes 2 No 2 Accident 6 Could not ba 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) in 24 hour.
The Funeral Direction of filled in by 4 Homicida Hospital edicai 29a. Certifier 1 X Certifying Physictan: To the best of my knowledga, death occurred at the tima, deta and piace, end due to tha causa(s) and manner es steted 2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the causa(s) and menner stated. (Check only one) To the To the Complet 29b. Signatura and titia of certifia 29c. Licensa number 29d. Data signed (Month, Dey, Year) D25759 february 8, 1999 Munos 30. Nama and address of person who completed cause of death (ttam 23a) (Type, Print) Walter K. Naumann, M.D., PO BOx 247, Accident MD 21520

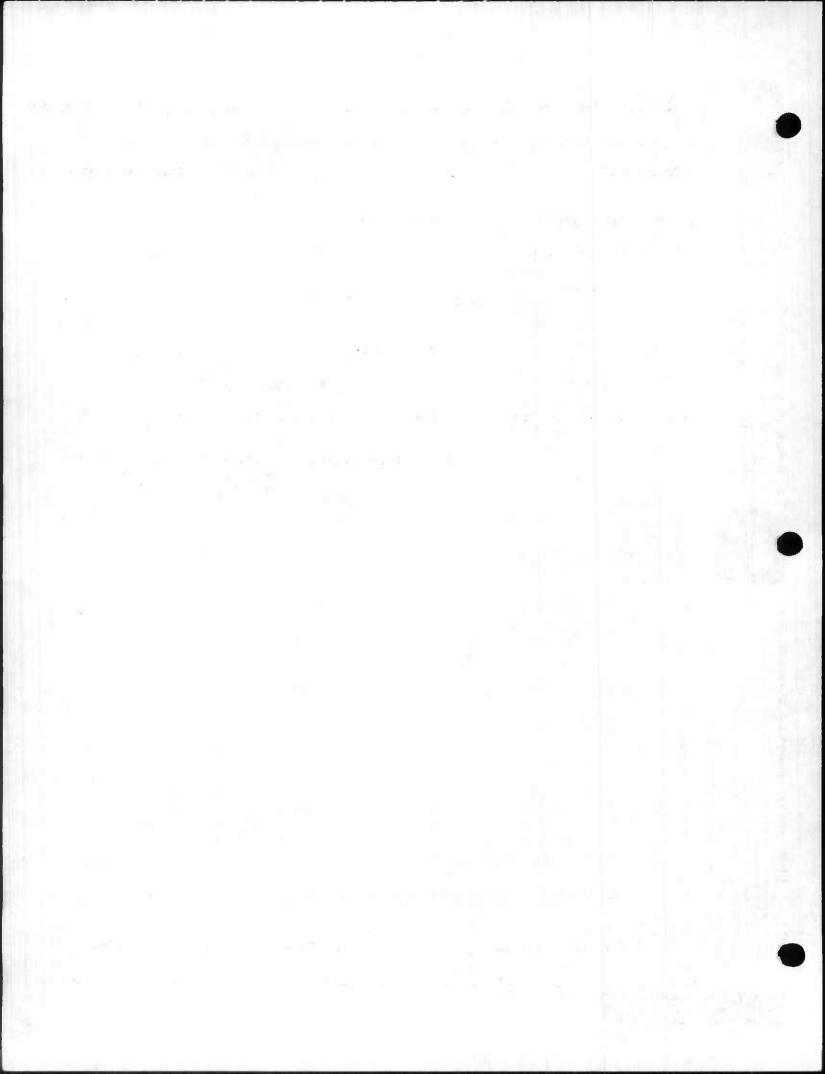
State Registrar 31. Data filad /Mo

32. Registrar's Signatura

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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ian	1. Dacadant's Name (F					ertificate		2. Data of D	Day	Yaar	3. Time of Death
cal	FRANCIS				ER,	JUNIOR		MARCH	6,6	199	9:20 AI
ner	4a. Facility Nema (If no BLOOKE GROV				128516	X= CONTS		or Location of Das Spelve		y of Death TGOME	014
7	5. Social Security Numi	ber 6. S	iex 7.		lest birthday	) If Under 1 Y	aar If Undar 24 H				
	578-14-921 Usual Rasidance of De	)	M 2□F	83	Yrs.	Months D	ays Hours M	oct. I	6, 1915	Washii	ce (Stata or Foreig
		b. County		10c. C	ty, Town or L	ocation				100	f. Inside City Limits
1010	MD M	ontgome	ery	S	ilver	Spring					1 □ Yas 2 No
Director	10e. Street and Numba					10f. Zip Co			10g. Citizan of	What Country	17
E	3700 Marbl	e Arch					r Spring		USA		
by Funerai	11. Marital Status  1 □ Navar Married  3 □ Widowed 4 □		12. Was Decede Armad Force 1 X Yes 2 If Yes, Giva Yaar or Data	s?			of Hispanlc Origin? Cuban, Maxican, Pu No Specify:	(Spacify Yas or N erto Rican, atc.)	lo- 14. Rai Bla Specif	ce - Amaricar ck, Whita, et by:	
ted		Dacedent's Ed	ducation		16e. Dac	edant's Usual O	ccupation		16b. Kind of B	usinass/indu	stry
Completed	Elementery/Seconda	onfy highest gre ry (0-12)	College (1-4	or 5+)			ona during most of v atired)	vorking			
Co	12	A Related to the			Dry	Cleaner			Cloth		
o Be	17. Fethar's Nama (Firs Francis Ga							łama (First, Middl Le Rupper		na)	
P	19a. Informant's Neme				19b. Mai	ling Address (S	raat and Numbar or			. Stata, Zip C	ode)
	Marion V.	Gaegler	/Wife		3700	Marble	Arch Way,	Silver	Spring,	MD 20	906
	20a. Mathod of Disposit		Removal from Sta		Plece of Disposamatary, cre	osition (Nama o	f place)	Date	20c. Location	City or Town	n, Stata
	4 Donation 5			Gat			Cemetery		Silver		
	21. Signetura of Funera	Tiles			S	lome, In Silver S	ddrass of Facility F.c. 500 Un pring, MD	iveristy 20901	Blvd.,	ns Fun West	eral
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	Immediata Causa (Fina	al .		00.							Onset and Death
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ner			b. HYPEA		or as a conse					U	GADS
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al E	Sequantially list condition if any, leading to immacausa. Enter Underlyin Causa (Disease or Injurthat initiated avents	g y	C							1	
dic	that initiated avents resulting in daath) Last			Dua to (d	er es e conse	quance of):					
			d			6 =					
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hys											he cause of death bly 455 Unknov
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mp										of de	ath?
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	27. Mannar of Deeth		28a. Data of in		28b. Tima o		njury at Work?		how injury occur		
atio	1 Natural 5 2 ☐ Accidant	☐ Panding invastigation		Jay rear)	Injury		1 Yas 2 No				
Certification:	3 ☐ Suicida 6 4 ☐ Homlcide	Could not be datamined	28a. Place of	Injury - At he atc. <i>(Specif</i>	oma, farm, si	raat, factory, of	ice	28f. Location City or To	(Street and Numb own, Stata)	per or Rural F	Routa Number,
edical	29a. Cartifiar (Check only one)	Certifying Phy Medical Exam	relcien: To the bas iner: On the besis and menner	of axamina	wledge, daat tion end/or in	th occurrad at the	a time, data and pla ny opinion, deeth oc	ca, and dua to the curred at tha tima	causa(s) end ma , date and place,	annar as state and dua to th	ed. na causa(s)
M G	29b. Signeture end littla	of certifier	anomenne	stateu.		29c. Lic	ense number		29d. Data signe	d (Month, Da	v, Year)
			STACE ON	16.00							
	30. Nama and address of GLACE BROOM 31. Data filed (Month D	of person who c	completed cause of	death (Item	n 23a\ (Tuno	Print)			- www	1,00	



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 1 6 9

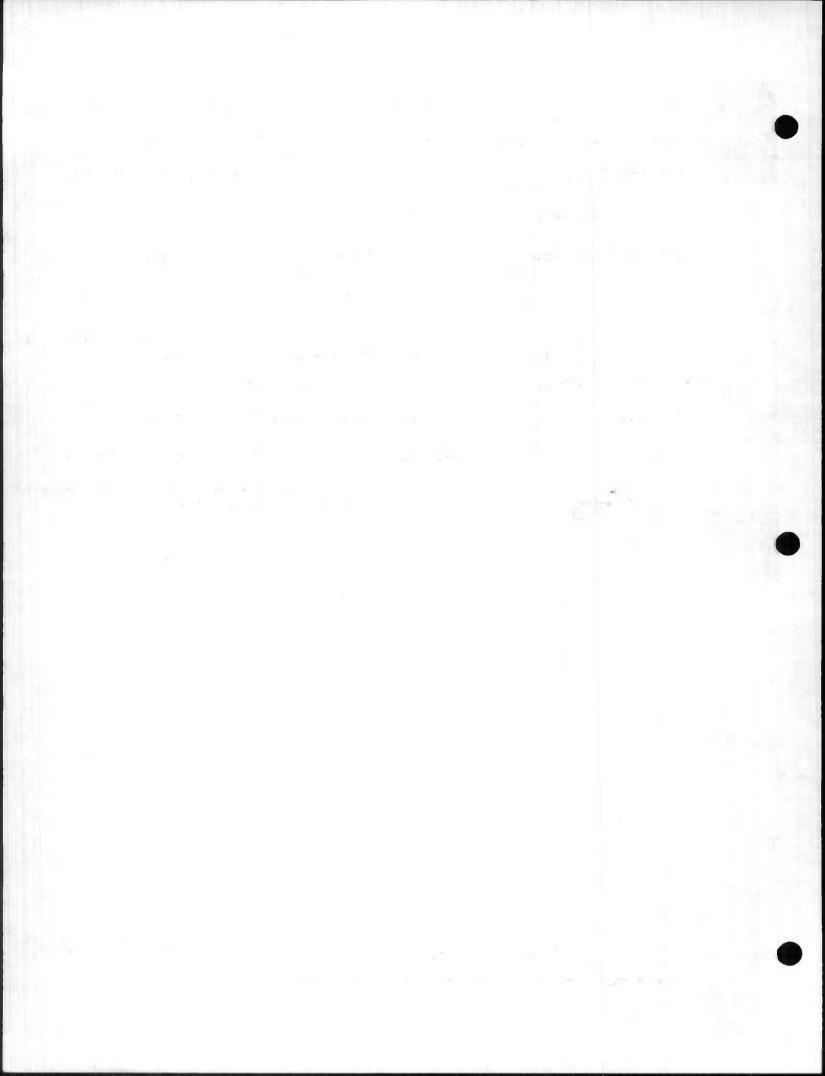
						Cen	tifica	ate of	Death		Reg. No.	0:	9109	
		Decedant's Nama	(First, Middle, L	ast)						2. Data of Do	eath Day	Yaar	3. Time of Dea	ith
cian dical	_		MARY	C.	GARRI	ETT				MARCI	,	1999	1:05 A	M
ner		Facility Nama (#	not institution, g	iva street and numb	per)				4b. City, Town, or	Location of Deal	h 4c. County	of Death		
		DO	CTORS C	OMMUNITY	HOSPI	TAL			LANHAM		PRI	NCE G	EORGES	
	5.	Social Sacurity Nu	ımber 6.		Aga (In yrs.	last birthday)	If Und	ar 1 Yaar s Days	If Under 24 Hrs Hours Min.	8. Data of Bi	rth ev. Year)	9. Birthple	aca (Stata or Fo	reign
	U	579-42-9 suel Rasidence of	/	1□ M 2□(F	65	Yrs.				8. Data of Bi (Month, D	28,1933	WAS	H. D.C.	
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by Fu		1 ☐ Nevar Marris 3 ☑ Widowed		1 Yas 2 If Yas, Giva Yaar or Date	No			2 ¼ No			Specif	y:	HITE	
2			15. Decedant's I	Education		16a. Deced	ant's Us	sual Occup	pation		16b. Kind of B			
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		4 Donation		□Ramoval from St cify)		ARYLAND	NA	TTONA	L CEM.	3/15/99	LAUF	EL. M	D.	
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		1 8	- 11	oreaM	/			D	422		MARC	H 11,	1999	
	30	0. Nama and addra	ss of person who	o complated cause	of daath (Ita	m 23a) (Type, F	Print)							
		E. FI	LORES, M	.D. 57	711 SA	RVIS AV	Ε.,	302,	RIVERDAL	E, MD.	20737			
ate	3	1. Data filad (Monti	n, Day, Yaar)	32. Peg	istrar's Sign									
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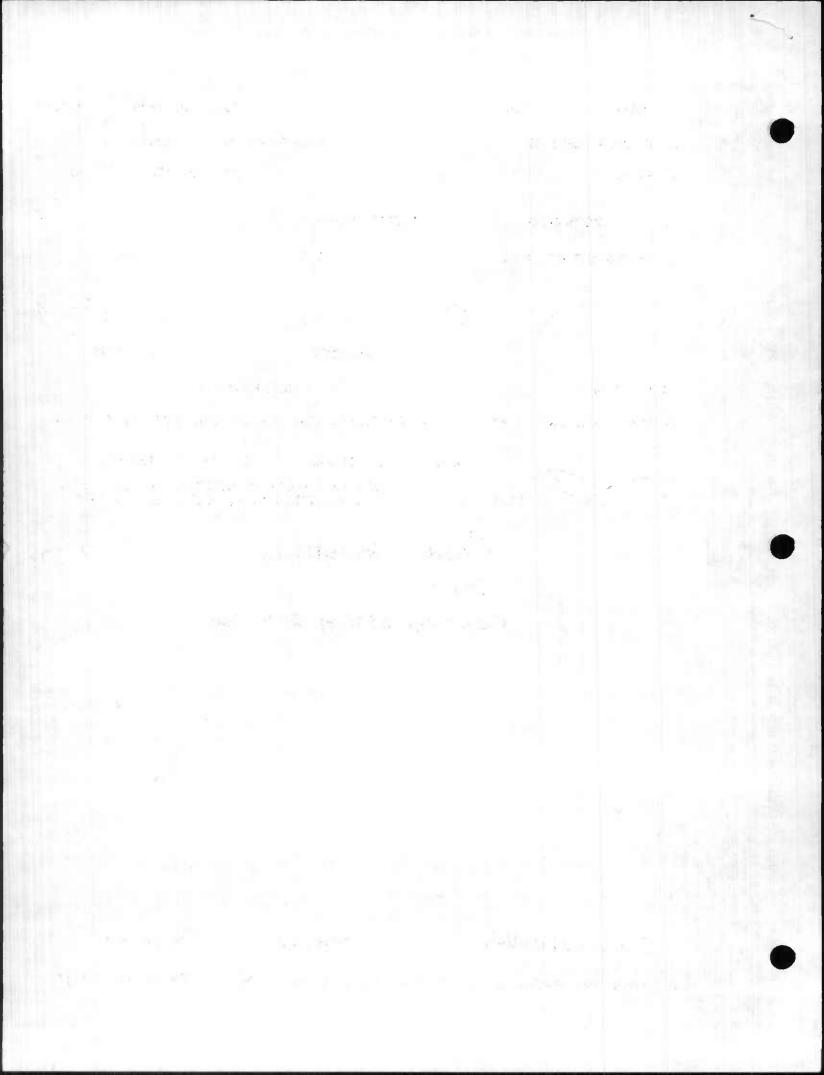
State of Maryland / Department of Health and Mental Hygiene 9

							Cer	tificate	e of	Death		Reg. No.	U	911	U
	Physic		1. Decedant's Nama (First, Gladys	Middla, La	st)		Giese				2. Data of De Month March	Dev	Yaar	3. Time of 9:50	
	/Medi Exami		4a. Fecility Neme (If not inst	itution, giv	a street and number,				1	4b. City, Town, or			of Death	7.50	C. VIII V
L			Shady Grov							Rockvi		Mont	gome	ery	
	Funeral Director		5. Social Security Number 577–38–1658 Usuel Rasidence of Daceda	1	6ax 7. Ag □ M 2⊠F 78		last birthday) Yrs.	If Under 1	Days	If Undar 24 Hrs Hours Min.		th y, Year) 2, 1921		place (State of htry) York	r Foraign
	land		10a. Stata 10b. Co			10c. Cit	y, Town or Loc	cation					1	0d. Inside Ci	ity Limits
	Many Firsh	ō	MD Mont	gome	ry	Bet	hesda							1 Yas	2 □ No
	or 284	lrec	10e. Street and Number					10f. Zip (	Coda			10g. Citizan of V	Vhat Coun	ntry?	
	23a 23a	al	6209 Dahlone	ga R	oad			208	16			U.S.A.			
Maryland 21215-0020	72 hours after death with the Maryland nature!', or items 23s or 28s-1 show yest. Examiner must be notified at	by Funeral pirector	11. Marital Status 1 ☐ Navar Marrled 2 ☐ 3 ☑ Widowad 4 ☐ Dive		12. Was Decedant Armed Forcas? 1  Yas 2 X If Yas, Giva Yeer or Datas:					lispanic Origin? (Sen, Maxican, Puar Specify:	Specify Yas or No to Rican, atc.)	14. Rac Biad Specify	k, Whita,	cen Indian, atc. nite	
5-0	"naturel",	pete		edent's Ed	ducation da complatad)		16a. Deced	ant's Usual	Occup	eation during most of wa	rkina	16b. Kind of Bu	sinass/inc	dustry	
121	- 3	Be Completed	Elementery/Secondary (0	12)	Collega (1-4or	5+)				during most of wo	ining	Nationa	1 In	stitut	e Of
2	e filed withing Hygiena.	100	17 Father's Nama (First, Mi	-	4+		Grants	s Admi	lnis	trator	no (Cient Adiaballo	Health	-1		
and	d be f	Be	Charles Law W							Marie Ba		Maiden Sumam	a)		
Z	should be and Mental marked o	To	19a. Informant's Name/Raia				19h Mailin	a Address	/Streat	and Number or Ri		er City or Town	State 7in	Code	
Z	od 2 s		Alan Giese		Son					Road, H				COUB)	
Baltimore,	permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiena. Important: If item 27 is marked other than any Injury or other traumatic event, the Mones.		20a. Mathod of Disposition 1 □ Burial 2 ☑Crama 4 □ Donation 5 □ Oth			C	iace of Dispos amatary, crem timore matory	atory or off	har plac	ton	Deta 3/11/99	20c. Location - Laurel,			
att	Departi Importa any Inju		21. Signatura of Funaral Sa	vice Licer	saa		22.	Nama and	Addra	ss of Facility					
<b>四</b>	225 2 2	4	1							ler's So ington,			Wisc	onsin	Avenu
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		N.			d										
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P.O.	that the day	Physician/M	Part II. Other eignificant cor	onions c	ontributing to death b	ut not rasi	ilting in the un	darlying ca	use giv	an in Part I.		tobacco uea com Yes 2√2 No		bably 4	
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Division of	or Att	Certification:	3 ☐ Suicida 6 ☐ C	ould not be tarmined							28f. Location ( City or To	Street and Numb wn, Stata)	er or Rura	I Routa Num	ber,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical (			yelclan: To the bast	axaminat									)
	To the within 2 To the comple	M		rtifier	11	/		29c.	Licens	e number		29d. Date signed	(Month,	Dey, Year)	
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	20		30. Name and eddress of	son who	complated causa of o	aath (Itam	23a) (Type, F			101		1-100	N	1)((	( -
_			Lee Penning	on,	M.D. 560	02 Sh	ields	Drive	, B	ethesda,	MD 2081	.7			
	Sta Registr	-	31. Data filed (Month, Day, )		32. Ragistr	ar's Signal	ture	100		,					



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	1. Decedent's Nat	ma (First, Middla, La	st)							2. Deta of D			3. Tima	of Death
cian lical	MAR	TIN	GILMAN							Month MAR.	10, 19	99 Yaar	8:3	9AM
ner	4e Facility Name	(If not institution, giv	ra street and nu	m <i>ber)</i>						cation of Dea		nty of Death		
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		Name/Ralationship ( M. GILMAN				-					ber, City or To			06
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		5 Other (Special Funeral Special Lieu		CHI	ELTENHA	Name and	Addra	es of Facility	,					
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State of Maryland / Department of Health and Mental Hygiene

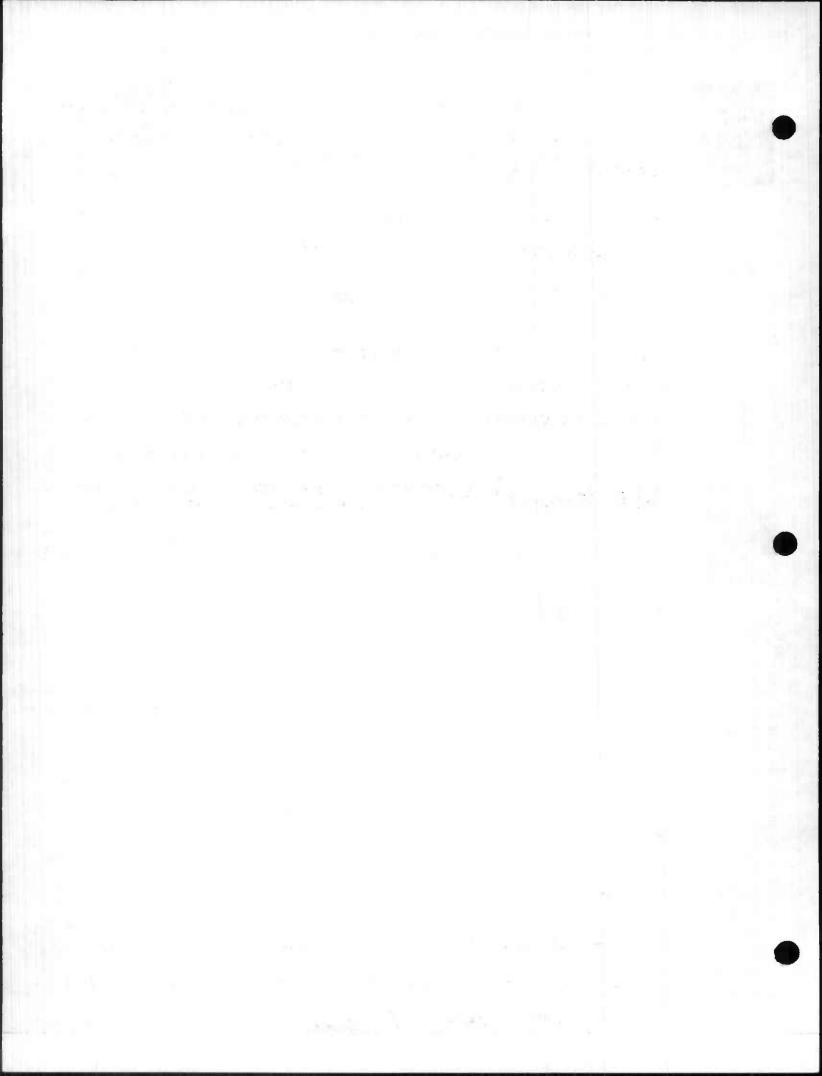
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physiclan** GARNER MARCH 1999 3:00 AM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 96 WEST EARLE AVENUE EASTON TALBOT If Under 1 Yeer If Under 24 Hrs.

Months Days Hours Min, 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗇 F 87 212-28-9423 Yrs Director July 19, 1911 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d. inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Moulcal Examiner must be notified at Director TYPS 2□No TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 96 WEST EARLE AVENUE 21601 USA permit. Pages 1 and 2 should be filed within 72 hours efter death 1 Depertment of Health end Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event. It a Mental Engles. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes XXXNo Specify: Specify: WHITE py 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) 12 0 SALESPERSON LUGGAGE 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **EDMUND** GREENWOOD ROSE DAVIS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT G. ALDRICH/NEPHEW 19 VALLEY CROSSING CIRCLE, COCKEYSVILLE, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
SPRING HILL CEMETERY 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from State 3-12-99 EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Neme end Address of Facility CFSPFELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Intervel Between Onset and Death **Physiclan** /Medical Immediete Cause (Finel PNEUTONIA disease or condition resulting In death) Examiner Due to (or as a consequence of): Sequentially list conditions, if eny, leeding to immediate causa. Entar Undarfying Cause (Disaasa or Injury that Initiated evants resulting in death) Last and Due to (or as a consequence of): Box 68760. ettending physicien The law requires that the deeth certificate be Physician/Medical \$ Due to (or as a consequence of) 98 P.O. Part II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Deen page 2 certificate hes 1 Yes 2000 Division of Vital the Hospital or Attanding Physician: Be 25. Was cese rafarred to medical 26. Place of Death (Check only ona) 1□ Yes 2□ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 2 After this 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: Natural 5 Pending death. 1 ☐ Yas 2 ☐ No 2 Accidant Investigation Director: 6 Could not be detarmined 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide within 24 hours of To the Funeral t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and mannar as atated.

2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Cartifier completely (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) C. W. Prai D.D D00250 30. Name and addrass of person who complated cause of death (Itam 23a) (Type, Print) C.R.W. BMN, 609 DUTCHTIMIS LAME, FASTON 32. Registrar's Signature 31. Date filed (Month, Day, Year) pereva G. Sparks Registrar MAR 1 0 1999

DHMH 16 Ray 6/95



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth MARCH 5 1999 MILTON C. GROSS 23:25 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death TAKOMA PARK MONTGOMERY WASHINGTON ADVENTIST HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) 11M 2□F 216-16-4982 Yrs. JAN. 1924 MARYLAND 10 Usual Residenca of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits MARYLAND ANNE ARUNDEL ANNAPOLIS 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 US 235 FARRAGUT ROAD 12. Was Decedent Ever in U,S. Armed Forces? 1≜ Yes 2 □ No If Yes, Give W • W • II Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 14 Never Merried 2 Married 1 Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) Coilege (1-4or 5+) ANNAPOLIS BUS CO. 7th BUS DRIVER 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) LOUISE DIGGS MILTON GROSS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 235 FARRAGUT RD. ANNAPOLIS, MD. 21401 WANDA DOYLE (DAUGHTER) 20b. Piace of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date MARYLAND VETERAN CEME..3/12/99 CROWNSVILLE, MD Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Servica Licansee 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 23a. Part! Enter the disease, or compile ations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final elebrores cerbi disease or condition resulting in death) Due to (or as e consequence of): Duelo (or as e consequence of Ql Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Was an autopsy performed? 2 X No 1 ☐ Yes 1 □ Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

PV

Completed

**Funeral** 

Director

7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Macical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. Internative them any Injury or other traumate.

Baltimore, Maryland 21215-0020

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death

Examiner Physician/Medical by Completed Be 2 Certification:

physician end the burial-trans for use es signed by the a been certificete has director, funeral

Box 68760 P.O. Division of Vital or Attending Physician: eftar death. Director: After this certifica To the Hospital or Atterwithin 24 hours efter der To the Funeral Director completely filled in by the

> State Registrar

Medical

30. Name and address of po DR, ANJUM

31. Date filed (Mont

Quz/

25. Was case referred to medical 1 Yes 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1) Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29d. Datesigned (Month, Day, Year) 29c. License number

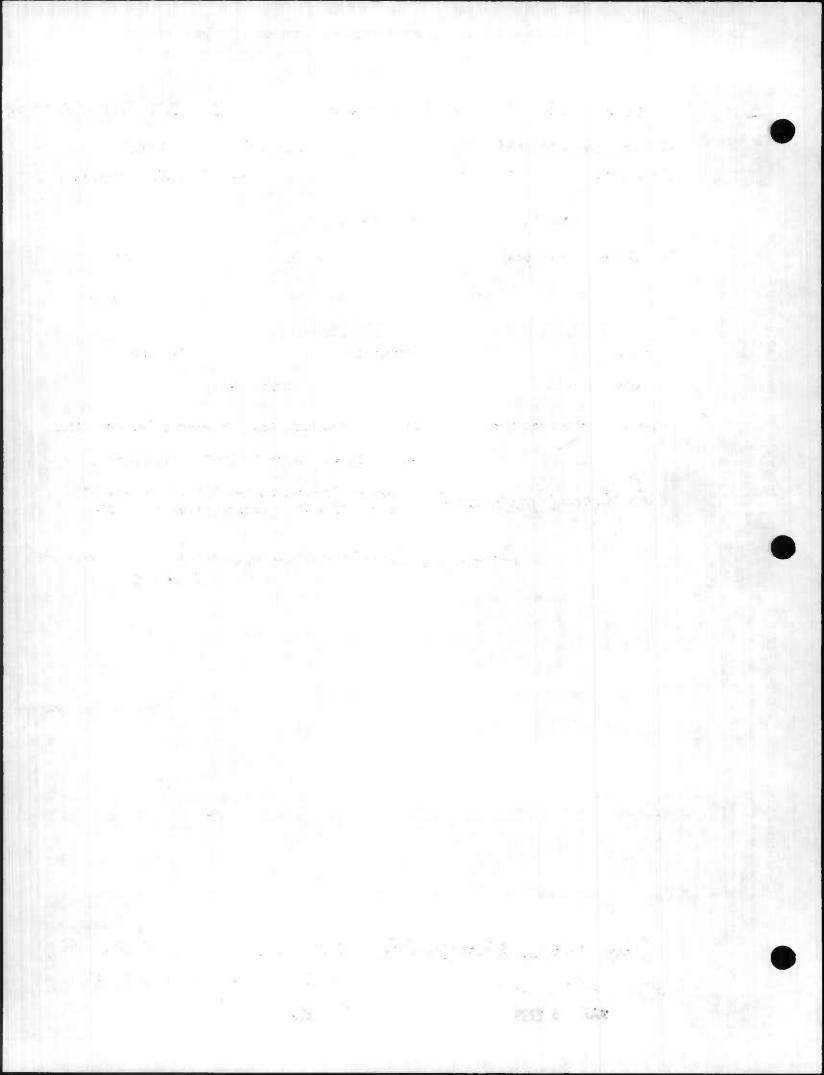
cause of deeth (Item 23a) (Type, Print) 7610 CARROLL AVE Takamom PK. Nd. 20912

32. Registrer's Signature

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9

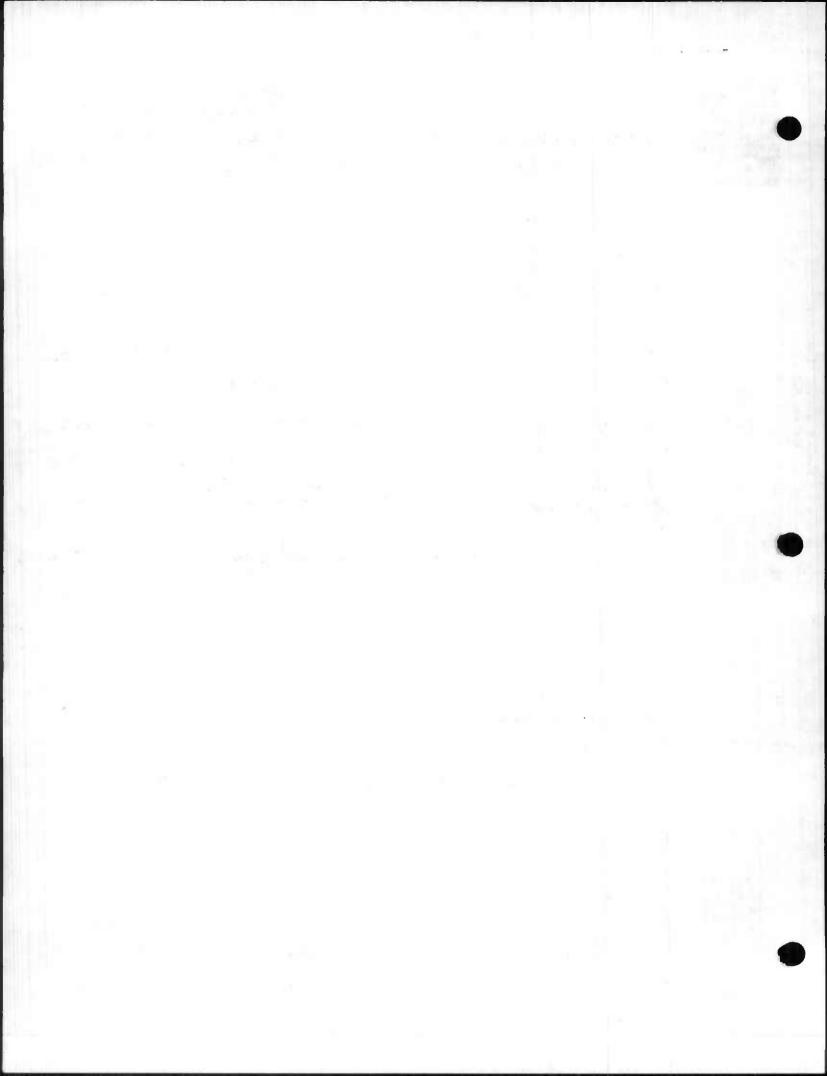
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210 Blooming Rose 5. Social Security Number 6. Se		rs. lest birthday)	If Under 1 Yea	Friendsv ar if Under 24 Hrs.	8. Date of Birth (Month, Dey	Garre	9. Birthplace (State or Foreign
	□M 2只F 77	Yrs.	Months Dey	s Hours Min.			Country)
Usual Residence of Decedent					Aug 16,	1921	Maryland
10a. Stele 10b. County	10c. 0	City, Town or Loc	ation				10d. Inside City Limits
MD Garre	stt.	Frier	ndsville	9			1 ☐ Yes 2 🙀 No
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210 Blooming Rose  11. Merital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forcas?	U,S. 13. W	Yes, specify Cu	f Hispanic Orlgin? (S uben, Mexican, Puert	o Ricen, etc.)		- American Indien, , White, etc.
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3 □ Widowed 4 □ Divorced	Year or Dates:		Α.				WIII CE
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Elementary/Secondary (0-12)	College (1-4or 5+)			red)			
12 th		Homen	naker			Own Home	
17. Father's Name (First, Middle, Last)					ne (First, Middle, i	Meiden Sumeme	)
Sherman Friend				Ethel	Kelly		
19a. Informant's Name/Relationship (T	ype, Print)	19b. Mallin	g Address (Stre	et end Number or Ru	ural Route Number	City or Town, S	State, Zip Code)
Lewis E. Gittere/	husband	210 F	Blooming	Rose Rd	. Friend	sville.	MD 21531
20a. Method of Disposition		Place of Dispos	sition (Neme of		Date	20c. Location - C	City or Town, Stete
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4 Donation 5 Other (Specify					, 1999	rrienas	ville, MD
21. Signature of Funeral Service Licens	0	/	Name and Add		00 D A	D 0 1	7 775
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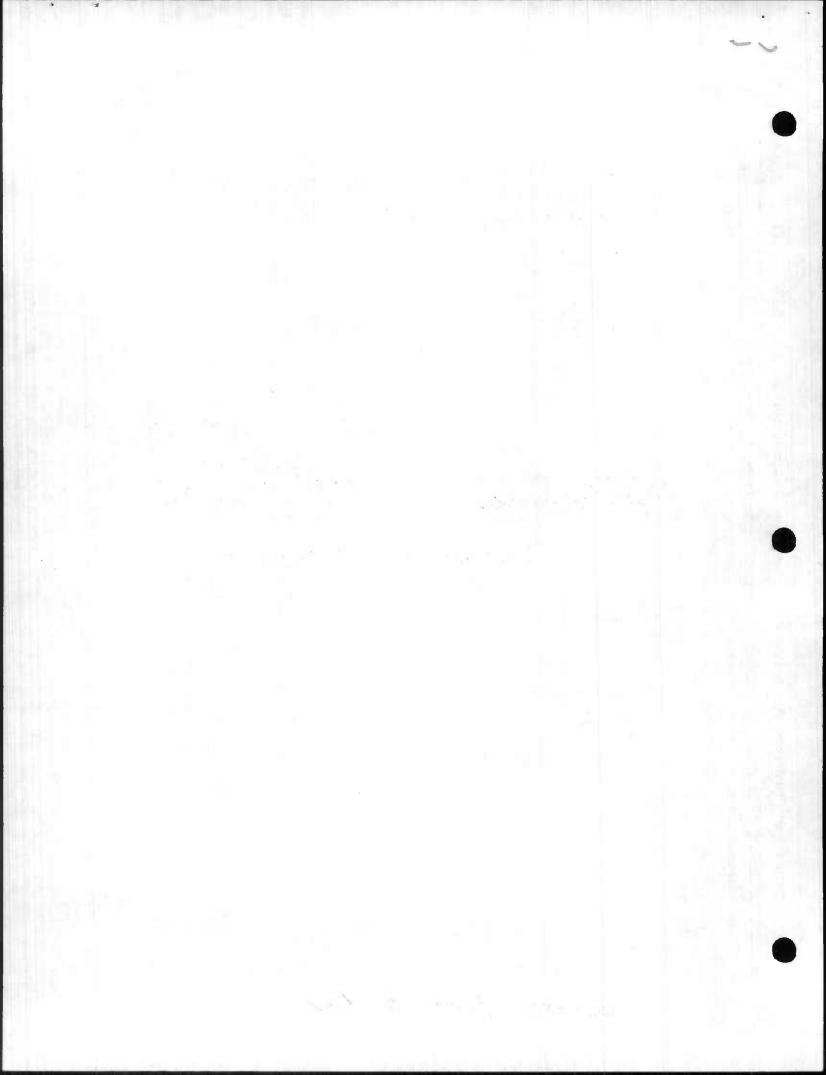
## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middle, La.	st)		Certific	alc or	Douin	2. Date of De	Reg. No.		3. Time of Death
Physici		Ro	se Mary	Gre	en			Month	Day + 8, 19	Year	03/2
/Medic		4a. Facility Nama (If not institution, giv					4b. City, Town, or Lo	MARC I			03/2
E Adrillo		PENINSULA REGI	ONAL MEDI	CAL CEN	TER		SALISBI	JRY	WI	COMICO	
Funeral Director		212-40-9255	FT . FT -	ga (In yrs. last b 57	Yrs. If Un Monti	nder 1 Year hs Days		8. Date of Bird (Month, Da Jan 30	y, Year) 0,1942	9. Birthplac Country Mary	a (State or Foreign y land
/ Amy / W		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Location					10d.	Inside City Limits
Maryla Maryla String at the store	ctor	Maryland Dorches	ster	F	Hurlock						1 ☐ Yes 2 XXVo
Control of the Mark De modifies	rai Director	10e. Street and Number 6307 Palmer Mil	.1 Road		10f.	Zip Code 21643	3		10g. Citizen of V US	Vhat Country	?
2.33 and 21215-0020 filed within 72 hours effer death with the Maryla tall Hygiens. d other than "natural; or lister 23s or 28s 4 shower, the Maryla at	by Funeral	11. Marital Status 1 ☐ Nevar Marriad ※※ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1  Yas  If Yes, Give Year or Dates:	?			Hispanic Origin? (Spi ean, Mexican, Puerto Specify:	ecify Yas or No Rican, etc.)	Specify	e - American ck, Whita, atc	
Maryland 21215-0020 As should be filed within 72 hours ef 12 should be filed within 72 hours ef 12 should be filed within 72 hours ef 12 marked other than "natural; or traumatic event, the Medical Exam	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed) Coilege (1-4or		_	work done Tuse retira	pation during most of worki id)	ing	16b. Kind of Br		
A C D Hilled		10 17. Falher's Name (First, Middle, Last)			Seamst	cress	18. Mother's Name	/First Middle		ing Fa	ictory
Id be ental kado	o Be	Lane Todd					Helen M		Trial de la contraction de la	,	
Maryland d 2 should be file the marked other traumatic event	To	19a. Informant's Name/Relationship (	Type, Print)	19	9b. Mailing Addr	ress (Street	t end Number or Rure		er. City or Town.	State. Zip Co	ode)
re, Maryle stand 2 should stand 2 should theath and Mer them 27 is marked other traumatic		Charles R. Green					Mill Road				
S to		20a. Method of Disposition 1 ∑ Surial 2 ☐ Cremation 3 ☐		20b. Placa	of Disposition (i	Name of		Date	20c. Location -		
Limo Page Ment: If		4 Donation 5 Other (Specify	/)	Green	Lawn C	Cemete	ery 3/	11/99	Cambrid	ge, Ma	ryland
Baltimore, M Permit. Pages 1 and 2 Department: Plages 1 and 2 Department: Riem 27 is eny injury or other tra		21. Signature of Funeral Service Licen	see				ess of Facility neral Home t Street (		ne Mary	land C	21613
		23a at 1. Enler the diseasa, or com	plications that cause	d the death. Do	o not anter tha m	node of dyi	ng, such as cardiac	or respiretory a	rrest,	A	pproximate terval Between
Physician /Medical Examiner	100	Immediate Cause (Final disease or condition resulting in death)					VFURCTI				nset and Death
	Jer			Due to (or as	e consequenca	of):				1	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attanding Physician: The law requires that the daath certificeta be executed within 24 hours aftar death.  To the Funeral Director: Aftar this cartificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	b	Due to (or as a	a consequence	of):					
Box 687 tath certificeta attending phys for use es the	Physician/Medical	resulting in death) Last	d	Due to (or as a	a consequence o	of):				1	
O. E daa e daa the att	sici	Part il. Other significant conditions co	ontributing to death b	out not resulting	In tha underlyin	ng cause gi	ven in Part I.	23b. Dld	lobacco use co	ntributa to th	e cause of death?
P.O. that the da by the set by the set detached	, Phy	RENAL H	=4160	RE				10	Yes 2□ No	3 Probab	oly 4 Unknow
Division of Vital Records, of Attanding Physician: The law requires the altar death.  Director: After this cartificate has been signed in by the funeral director, page 2 should be director.	Completed by	D.ARTES						24a. Was	an autopsy med?	24b. Wera availa comp of dea	autopsy findings able prior to letion of cause
De la	omp	CEREBRUM	21 . 11 m	1 47		17		10	res 25 No	1700011	es 2 No
ital	BeC	25. Was case referred to medical	73646/10	710	CLBSW		26. Place of Death				
of V nysicl nis can idirec	ToE	exeminer? 1 ☐ Yes 2∰ No	Hospital:	ent 2 ER/C	Outpatient 3	DOA Off	her: 4 Nursing Ho	-		er (Specify)	
Sion o anding Ph auth. or: Aftar th	Certification:	27. Manner of Deeth  1 19 Netural 5 Pending investigation		ay Year) 28b	. Time of injury	28c. Inju Wo			now injury occur		
Divis	Sertific	3 Suicide 6 Could not be determined	Zoe. Place of in	jury - At home, tc. <i>(Specify)</i>	farm, street, fac	etory, office		28f. Location (3 City or Tox	Street and Numb vn, Stele)	er or Rural R	toute Number,
Hospit 24 houn Funera etely fille	edicai	29a. Certifier (Check only one) 1 Certifying Phyone 2 Medical Example 1 Medical Exa	ysician: To the best liner: On the besis of and manner st	f exemination a	ge, deeth occurr ind/or investigati	red at the til	me, dete end place, oppinion, death occurr	and due to the ed at the time,	cause(s) and me dete end plece,	enner as state and due to th	ed. e cause(s)
2 5 2 5	ž	29b. Signature and title of certifier				29c. Licans			29d. Data signe		y, Year)
To the vithin To the compl	-	1 1									
To the within To the compl		· Rull				739	8353		3/8/99		
To the within To the compl	•	30. Name and address of person who of REAR RES A AND 31. Date filed (Month, Day, Year)  MAR 10 19					8353 MOL 6	or isan		1	ga4



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 0 9 1 Certificate of Death Reg. No.

				(	Certificate of	Death	F	Reg. No.	09	1/6
	Physician /Medical	1. Decedent's Neme (First, Middle, Las EARLE A	HINES				2. Date of Dea Month MARCH	Dey ,		Tima of Death  1:45AM
100	Examiner	4a Facility Name (If not institution, give HUSPICE HOUSE	street and number)			4b. City, Town, or L EASTON			and control	
	uneral rector	5. Social Security Number 6. Se 220-32-7602	du offe	(In yrs. last birth	Months Days		8. Date of Birth (Month, Day 3//3/		9. Birthplace Country) Marylar	(State or Foreign
Maryland	Mad at	10a, Stete 10b, County MARYCAND TALB	and the second s	EASTO			1/			nsida City Limits
th with the	23a or 28 mat be no ral Direc	10e. Street and Number 609 DOVER RD			2 / 6	01		10g. Citizen of V		
020 ours after dea	rai', or terms 23a or 28a-f show Exacting must be notified at	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Wea Decedent Ev Armed Forces? 1 ☐ Yes ② No If Yes, Giva Year or Detes:		13. Wes Decedent of If Yes, specify Cut	oan, Mexican, Puerto	pecify Yes or No- Pican, etc.)	Bled	a - American Inck, White, atc.	dian,
15-C	inette	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12th		, ,	Decedent's Usual Occu Give kind of work done life. DO NOT use retire Oduction S	during most of world)			Decker	Mfg.Co.
Maryland	De vot	17. Fether's Neme (First, Middle, Last)  Cortland C. Hine	S			18. Mother's Nam Lola M.		Maiden Suman	ne)	
Mar 12 sh	tom 27 le marke other treumatic TO	19a. Informant's Name/Reletionship (7)			Mailing Address (Stree					9)
_ 5 %	Nem 27 other tr	Edwina Hines, Si	ster		.O. Box 293	, Camden,	Delawar	e 1993 20c. Location -		State
0 5 %	important: If Hi any Injury or o once.	1 ☑ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		cemetary	crematory or other pla Grove Cem	etery	3/13/99			
Demil Depart	eny in	21. Signature of Funezal Service Licens	mul			Smith Fur ox 1687, 1				
/Me Exar	sician edical miner	Immediate Cause (Final disease or condition resulting in death)	. Meta		Columnsequence of):	n Ra	ucel_		Ons	rval Between et and Deeth
), executed	physician end is the burist-transit	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thell initiated eventa	b	ue to (or ea a co	onsequence of):					
-		reauting in death) Last	c	ue to (or as a co	nsequence of);					
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٠ ۽	signed by the attendind be detached for use detached for use deby Physician/N	Hyperleuso			and disconjung duality			/88 2□ No		11
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al Rec	Com			7112		. 200	1 U Y	es 20 No	1 ☐ Yes	200No
Vita	rector, pag rector, pag	25. Was case referred to medical axaminer?	Hospitel:		10	26. Place of Dee	th (Check only o	na)		
o &	5 p	1 ☐ Yes 20 No	1 ☐ Inpatient	2 ER/Outp	patient 3LI DOA	4 □ Nursing H	ome 5 Resid			ospice Home
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Division of or Attending	al Director: Aftertied in by the funeral	3 Suicide 6 Could not be detarmined	28a. Place of tnjury building, atc.	r - At home, fam (Specify)	n, street, factory, office		28f. Location (S City or Tow	itreet and Numb n, State)	er or Rural Rou	ıta Number,
To the Hospital within 24 hours	To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physical Examile	sician: To the best of r ner: On the basis of er and manner state	kamination end/	death occurred at the ti or investigation, in my	ima, data and place, opinion, death occur	and dua to the or red at tha tima, o	cause(s) and ma data and place,	nnar as stated. and dua to tha	cause(s)
Toth	Comp	29b. Signature and title of certifier		_	00	o 5 3 \$ 15	/	29d. Date signe	10/90	
		Name and address of person who co	ompleted cause of dear	th (Item 23a) (T		+ 5th	WE, DE	NIWI	mb 21	629
	State	31. Date filed (Month, Day, Year)	32. Register's	Signeture	B. Spa	Kir.				



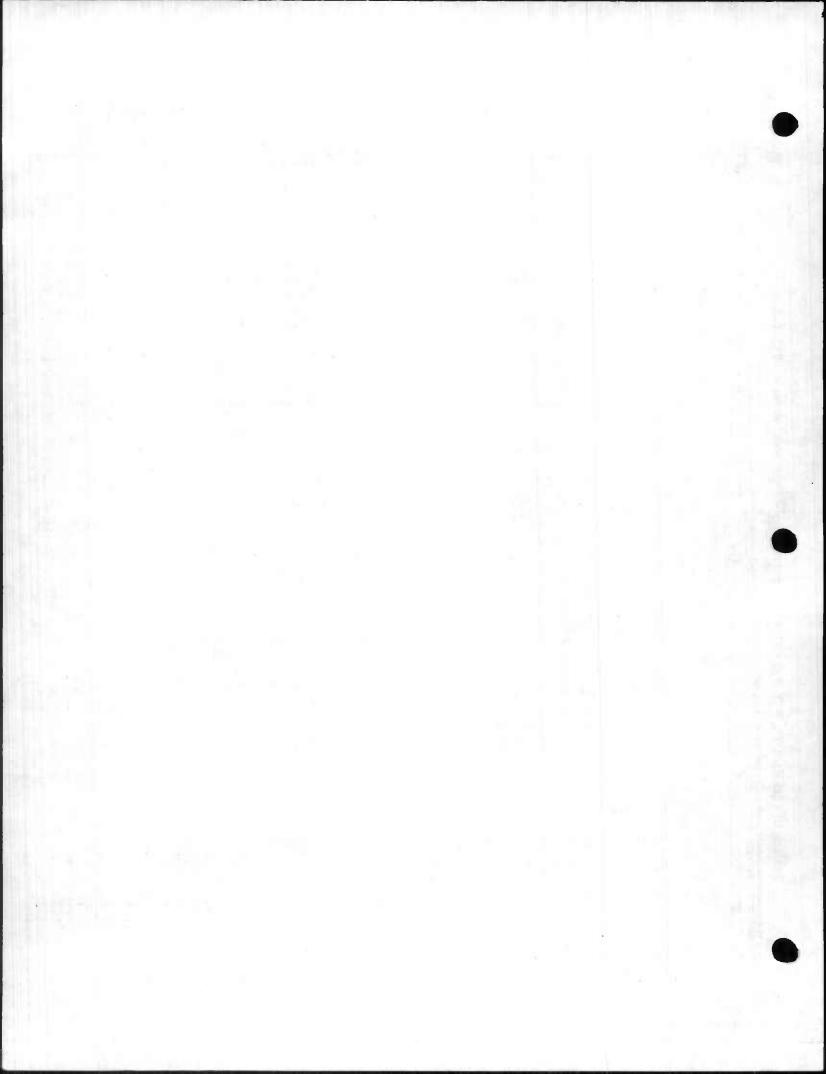
HUMPHREYS, CURTIS

Physician	Curtis Cleve	Humphreys 9	r					Month	Dey	Yeer	3. Time of Deetr
/Medical			,,,			4h City Tou	un orlo	MARCH A		-	4:35 p.n
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uneral		Sex 7. Age 1₩ 2□ F	(In yrs. last i	Yrs. Month	der 1 Year	If Under 2 Hours	Min.	8. Date of Bir (Month, De	h y, Year)	Cour	ece (State or Fore
irector	214 10 0000	Xm	82	118.				May 26	, 1916		MD
2	Usuel Residence of Decedent  10e. Stete 10b. County		10c City To	wn or Location						1	0d. Inside City Lim
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be notified Director	10e. Street end Number			10f.	Zip Code				10g. Citizen of	Whet Cour	ntry?
<u></u>		ghway		2	1502				USA		
Funeral	11. Meritel Status	12. Was Decedent 8 Armed Forces?	ver in U,S.	13. Wes De	cedent of h	lispenic Origen. Mexicen.	in? (Spe	ecify Yes or No Rican, etc.)	- 14. Rad	ca - Americ	ean Indien,
II.		1 Yes 2 X	lo			Specify:			Specif		0.0.
by	3 ☐ Widowed 4 ☐ Divorced	Yeer or Detes:		12.00	1 21,10	ороспу.			Specif		ite
Completed	15. Decedent's E (Specify only highest go	Education	16	ie. Decedent's U	suel Occup	ation	of work	ina	16b. Kind ot B	usiness/In	dustry
ple	Elementary/Secondary (0-12)	College (1-4or 5	+)	(Give kind of life. DO NO	use retire	d)	Or WORK	n ig			
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Bec		r)				18. Mothe	r's Name	(First, Middle	Maiden Sumer	ne)	
0		Humphrevs				Gert	rude	(Insle	evs)		
-	19e. Informent's Name/Relationship		1	9b. Mailing Addr	ess (Street				-	Stete, Zip	Code)
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	20e. Method ot Disposition	0,0 0011		ot Disposition (i			010	Dete	20c. Location		
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	4 □ Donetion 5 □ Other (Spec	•	Cumbe	rland C				3/05	Cumber	land	, MD
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	Ymholas	1 MA	1000			I, MD					
	23e. Pert1. Enter the diseese, or cor shock, or heart tailure. List ont	plications that caused	the death. D	o not enter the n	node of dylr	ng, such es	cardiec	or respiretory a	rrest,		Approximate Interval Between
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I for use as the bunar-transit clan/Medical Examir	resulting in deeth) Lest		Due to (or es	e consequenca o	of):						
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-		28e. Dete of Injur		. Time of			-		how injury occu		(9)
ion	1 Naturel 5 Pending	28e. Dete of Injur (Month, De)	Year)	Injury M	28c. Inju	rk?  Yes 2∐1	No				
Certification:	2 Accident Investigation 3 Suicide 6 Could not	be on Place of lair	a. Athomo			100 20	+	29f Location /	Street and Num	her or Bur	al Route Number,
THE	4 Homicide determine	28e. Plece of Inju- building, etc	(Specify)	rem, street, rec	tory, onice			City or To		Der or rian	ar rioble rvamber,
2											
edical	29e. Certifier 1 Certifying P (Check only one) 2 Medicat Exa	hysictan: To the best of miner: On the basis of	exeminetion	ge, deeth och in Ind/or lnvestigat	ed et the tir i <i>on</i> , in my d	me, date en opinion, deel	d plece, th occur	end due to the red et the time,	ceuse(s) end m dete end plece,	enner es s and due t	stated. o the ceuse(s)
Me	29b. Signature and title of certifier	and manner sta	ted.	1	29c. Licens	a number	-	-	29d. Dete signe	ad /Month	Day Veer)
	and adjusted that the organizer	11 /	1	/	and animalia	or commons			Lou. Gate aight	- (month)	-ay, rour,
	1/200	1 /1	- /		D 30	159			MARCH [	5,	1999
				-							
	30. Name and address of person who	completed cause of de	eath (Item/23a	i) (Type, Print)							
4	30. Name and address of person who KENNETH A. ROCK,	M.D. MEMOR		SPITAL,	SUIT	E 402	CUM	BERLAND	, MD 21.	502	
State		//	IAL HO		SUIT	E 402	CUM	BERLAND	, MD 21	502	

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State of Maryland / Department of Health and Mental Hygiene 99 09 78

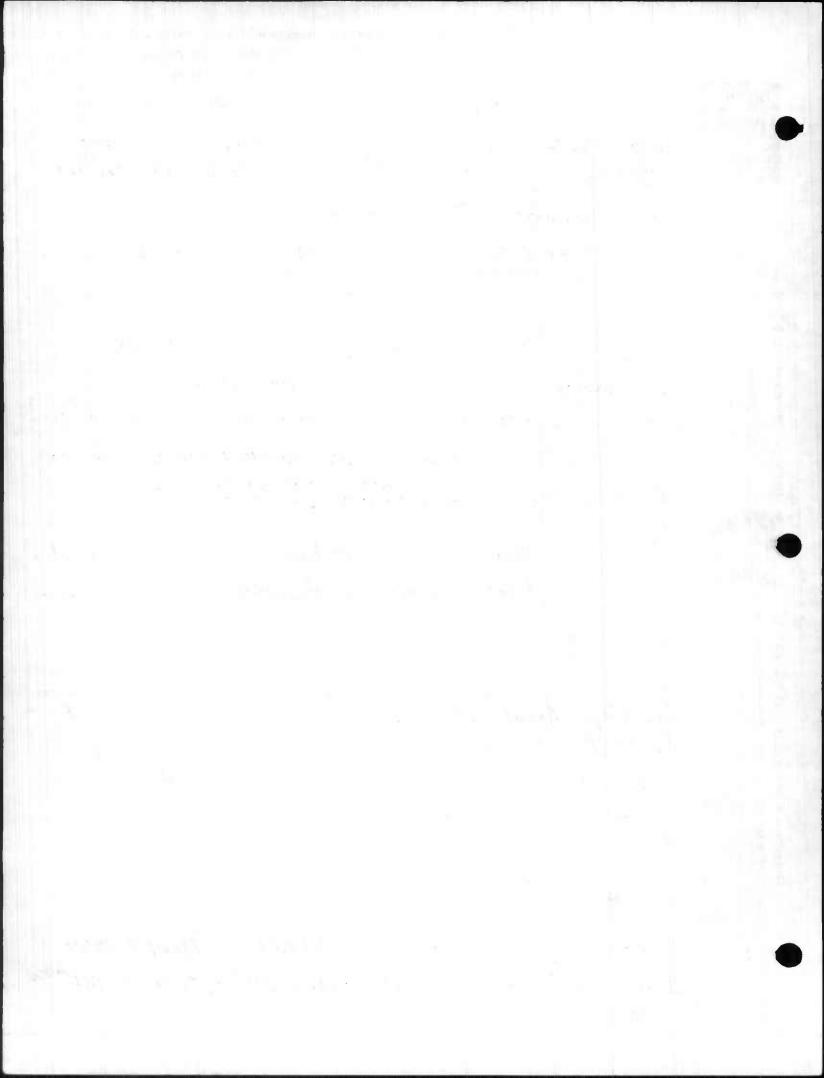
		Otate of Islanyia		tificate of			eg. No.	091/0
Physician	Decedent's Nama (First, Middle, Las	1)				2. Data of Dea Month		3. Time of Death
/Medical		Hadlick, Jr.			4b. City, Town, or	March	10, 19	99 3:15 PM
Examiner	4a Facility Name (If not institution, give 3601 Tarkington				Silver Sp		Montge	
Funeral Director	5. Social Security Number 6. Se		last birthday) Yrs.	If Under 1 Yae Months Days	If Under 24 Hrs	8. Data of Birth	Year)	9. Birthplaca (Stata or Foraign Country) New York
2 .	Usual Residence of Decedent	140.00						
with the Marylan a or 28s-f show Lbe notified at Director	MD Montgome		ity. Town or Loc Silver					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
h with the Me 23s or 28s-f s at be notified at Director	10e. Street and Number 3601 Tarkington L	ane		10f. Zip Code 20906		1	0g. Citizen of W	het Country?
15-0020 72 hours after death with the Marylar "returnt", or hems 23s or 28s-f show diffiel Examiner must be notified at leted by Funeral Director		12. Wes Decedent Ever in U Armed Forces? 1 12 Yes 2 1 No 1 - 5 If Yes, Giva Year or Dates:	J,S. 13. V 59 1	Ves Decedent of Yas, specify Cul	Hispanic Origin? (S ban, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		- Amarican Indian, , Whita, atc. White
Maryland 21215-0020 d.2 should be filed within 72 hours at the and Merial Hyglere. 7 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by F	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Giva I	O NOT use retin	a during most of wo ed)	rking	16b. Kind of Bus	
C Hade	17. Father's Nama (First, Middle, Last)	<u> </u>	Speeci	Therap		ma (First, Middle,	Educat	
yland Wantal H Wantal H wantal H affe ever	D 1 H H 11 11 1	Sr.				ohine Del		
C 2 W F	19a. Informant's Name/Relationship (7) Lola A. Hadlick/w				on Lane,			
Pages 1 named the mit if then ary or oth	20a. Method of Disposition 1 ⊠ Burial 2 □ Cremetion 3 □ I 4 □ Donation 5 □ Other (Specify,	Removal from State	cemetary, cram	sition (Nama of patory or other pla leaven C				City or Town, Stata Spring, MD
Balt permit, Departu importu any inji	21. Signature of Funeral Service Licens	1000	Ho	ome, Inc	ass of Facility Fr . 500 Uni			s Funeral West
Physician	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deal one cause on each line.			-	c or raspiratory are	est,	Approximate Intervat Batween Onsat and Death
/Medical Examiner	Immediata Cause (Finel disease or condition resulting in death)	e	on-smal		lung cand	cer		1 year
68760, illicate be executed g physician and set the burlet-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (c	or as a consequ	uence of):				
= a = =	resulting in death) Last	Due to (c	or as a consequ	sence of):				
BOX entendin for use				190				
P.O. BOX het the death cent de by the ettendin detsched for use Physician/M	Part II. Other significant conditions co	ntributing to death but not res	sulting In tha un	derlying causa g	iven in Part I.			tribute to the cause of death?  3 Probably 4 Unknown
DIVISION Of VItal RECORDS, P.O. BOX or Attanding Physicien: The law requires that the death car first death. Director: After this cartificate has been signed by the ettendin in by the funansi director, page 2 should be deteched for use ertification: To Be Completed by Physician/V						24a. Was a perfor		24b. Ware autopsy findings eveilable prior to completion of causa of death?
Laft Page C						1 U Y	as 2K) No	1 ☐ Yas 2 ☐ No
ortifica priffica peror, per	25. Was case refarred to medical examiner?				26. Placa of De	ath (Check only or	ne)	
Of VITAI Rec Physicien: The law if this certificate hes t arel director, page 2 s arel director, page 2 s	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3LI DON		loma 5⊠ Rasid	ence 8 DOtha	r (Specify)
DIVISION OF DIVISION OF All or Attending Phy after death.  I Director: After this of in by the funeral of in Extra Control of the funeral of the Control of	27. Manner of Death  1 🖾 Natural 5 Pending  2 Accident investigation		28b. Tima of Injury	28c. Inju W	ury at ork? ] Yas 2 ☐ No	28d. Dascribe h	ow injury occurre	d
DIVISION of the or Attending P as the death.  al Director: After the or in by the funer Certification:	3 Suicide 6 Could not be detarmined	28a. Place of Injury - At h building, atc. (Specif	oma, farm, stre	et, factory, office		28f. Location (S City or Tow		r or Rural Routa Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only 2 Medical Exam)	reiclan: To the best of my kno iner: On the basis of axamina and manner stated.	owledge, death ation and/or inv	occurred at tha t astigation, in my	ima, data and place opinion, daath occe	e, and dua to the curred at the time, o	ause(s) and man ata and ptace, a	nar ss stated. nd dua to tha cause(s)
Within To the compl	29b. Signature and title of certifier	11	14	29c. Licer	ise number		9d. Date signed	(Month, Dey, Year)
20+1	Marsh 13	Kudu	WM	D37	236		March 11	, 1999
	20. Name and address of person who co Carolyn B. Hendric				, #1345,	Chevy Ch	ase, MD	20815
State Registrar	31. Date filed (Month, Day, Year) MAD 1 9 199	32. Registrar's Signa	atura &.	Spark	21			177514



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

						Certific		Death		Reg. No.	J U:	11/9	
Physician		Decedant's Nama (First, Middle, Last)							2. Deta of Dea Month MARCH	8 Day 19		3. Time of Death	
/Medical Examiner		SYLVESTER HARVEY										0032 AM	
									or Location of Deeth 4c. County of Death				
		Shady Grove Adventist						Rockv					
Funeral Director		5. Social Sacurity Number  None  Usual Residence of December	6. Sax					8. Date of Birth Month, Day Jan . I	3 , 1939	9. Birthplac Country Jaint	e (Stata or Foraig aica		
d within 72 hours after death with the Maryland sjene. If then "naturel", or flems 23a or 28a-f show the Machinel Event her must be notified as	tor	Usuel Rasidance of Decedant  10a. Steta 10b. County 10c. City, Town or Location									10d.	Insida City Limit	
		MD Mo	ntgomer								1 XYas 2 N		
	I Direct	10e. Street and Number 425 N. Fr	ederick	Lck Ave. 10f. Zip Code				a 10g		_	g. Citizen of Whet Country?  Jamaica		
	by Funeral Director	11. Marital Status  1 Never Married 2 SMarried  3 Widowed 4 Divorced		12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yas, Giva Yaar or Datas:			13. Wes Dacedant of Hispanic Origin? (S If Yes, specify Cuban, Maxican, Puart 1 Yes 2X No Specify:			ify Yas or No- cen, atc.)  14. Race - American Indian, Black, White, etc.  Specify: Black			
C 1 3	Be Completed	(Specify only his Elementery/Secondery (0-	dent's Educetion ghest grada comp 2) Co	ucetion da completed) Collega (1-4or 5+)		16a. Decedant's Usual Occupation (Giva kind of work dona during most of wo lifa. DO NOT usa retired)			king	16b. Kind of Business/Industry Airport			
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should be filed within and Mental Hygiene. marked other than imatic event, the M	Be	17. Father's Neme (First, Middle, Last)  Cecil Harvey				18. Mother's Nema (First, F Iris Bri							
J Mer J Mer	10					19b. Mailing Addrass (Street and Number or Rural Routa Number							
12 should heard 7 to me		19e. Informant's Name/Ralet Delores M.			196	Mailing Add	rass (Street	and Number or Ru ederick	ral Routa Numbe	r, City or Town, Gaithe	state, Zip Co	da) 2007	
1 and Healt Pm 2		20a. Mathod of Disposition	nar vey	(WIIIC					Data	20c. Location -			
permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 te marke eny Injury or other traumatic once.		20a. Mathod of Disposition  1							/12/99	Monte			
permit. P Departmo Importan eny Injur		21. Signature of Funarai Sarvica Licenses  22. Nama and Addrass of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850											
minas that the death certificate be executed  signed by the attending physician and indicate the detached for use as the burial-transit	fedical Examiner	Immediata Cause (Final diseesa or condition rasulting in death)  Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disease or injury that initiated avants resulting in death) Lest	a. <u>V</u>	oron	u a to (or as a divided of the to (or a) divided of the (or a) divided of the to (or a) divided of the (or a) divided of			Disease	5-e		m y	inutes 1 ears	
	Physician/	that initiated avants resulting in death) Lest  Part II. Other significant con	d		not resulting in	n tha undarlyii		van in Part I.		obacco use co 'es 2 No		e cause of deat	
nee not	ted by	Prostate cancer				0.40			24a. Was a	an autopsy med?	avalla	autopsy findings bla prior to	
The law ate has b	Completed	Radiatio	7	•,,,,,,					1 U Y	1□ Yas 254No		letion of cause oth?	
lan: artific ctor,	Be	25. Was cesa rafarred to me	licel					26. Pleca of Das	th (Check only or	1a)			
physic this ce	2	1 Yas 2□ No	Hospital	Hospital: 1 ☐ Inpatiant 2 ← FVOutpatient 3 ☐ DOA Othar: 4 ☐ Nursing Ho						oma 5 Rasidence 8 Othar (Specify)			
To the Hospital or Attending Physicien: within 24 hours aftar death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	27. Magner of Death   Naturel   5   Panding   (Month, Day Year)				28b. Tima of Injury at Work?  M 28c. Injury at Work?  1  Yas 2 No			28d. Dascribe how injury occurred  28f. Location (Street and Number or Rural Routa Number,				
ospital or hours aft ineral Dir ly filled in	cai Ceri	4 Homicide building, etc. (Specify)  City or Town, State)  29a. Certifier  Check only  Cartifying Physician: To the best of my knowledge, death occurred et the time, data and place, and due to the ceusa(s) end mannar as stele									d.		
he Hi in 24 he Fu	edicai	(Check only one)  2 Madical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner stated.											
To with	2	29b. Signeture end title of certifier  29c. License number  D 3 7 02 4							March				
		D37024 March 8, 1999  30 Name and address of person who complated assa of death (Itam 23a) (Type, Print)  DAVID E. SROUR, M.D. 9901 Medical Ctr. Dr., Rockville, MO 2085.											
Sta	te	31. Data filed (Month, Day, Y		32. Registrar	s Signature	lon	11						



## Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** STEVEN HENRY 4,62An 00 1499 MARCH /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Washington Adventist Hospital MONTGOMERY Takoma Park If Under 24 Hrs. Hours | Min. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 10XM 2□ F Months Days 214-60-6159 44 Aug. 31, 1954 Wash. DC Director Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours eftar death with the Merylend neat of Health and Mental Hyglene.

Int: If fem 27 is marked other than "natural", or items 23s or 28s-f show this: If them 27 is marked other than "nature", or items 28s or 28s-f show that yo do not be not listed at any or other traumatic event, the Medical Exertines must be not listed at 10a State 10b. County 10c. City. Town or Location 10d. inside City Limits Rockville 1 Yes 2 □ No MD Montgomery Director 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 402 Monroe Street, #2 20850 U.S.A. Funeral 12. Was Decedenf Ever in U,S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 Specify: Black 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Montg. Co. Elementery/Secondery (0-12) College (1-4or 5+) 2 Vrs Instructional Ass't Schools yrs 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Irma L. Weeden Francis E. Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) 221 Elizabeth Ave., Rockville, MD 20850 Sheila F. Henry (Wife) 20b. Place of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State Demit. Page Department of Important: If it any Injury or of Burial 2 Cremation 3 Removal from State 3/13/99 Rockville, MD Lincoln Park Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart filture. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** SEPTIC SHOCK /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es a consequenca of): Examiner SFT HAND physician end the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evenfs resulting in death) Lasf Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): ettending pl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ed by the e 1 Yes 2 Probably 4 Unknown þ Sign De 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? per work s certificate has b DIABRITE 2 No 1 Yes 20 No Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificalety filled in by the funerel director, p. 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 1 Naturel 5 Pending Investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Phyaician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and menner as steted. Medical To the Hosp within 24 ho To the Fune completely (i (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 00052927 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)
THEODOLE I CHESE, 7600 CARS ,7600 CARROLL NENUS, TAKOMA PARM MD20912

Registrar

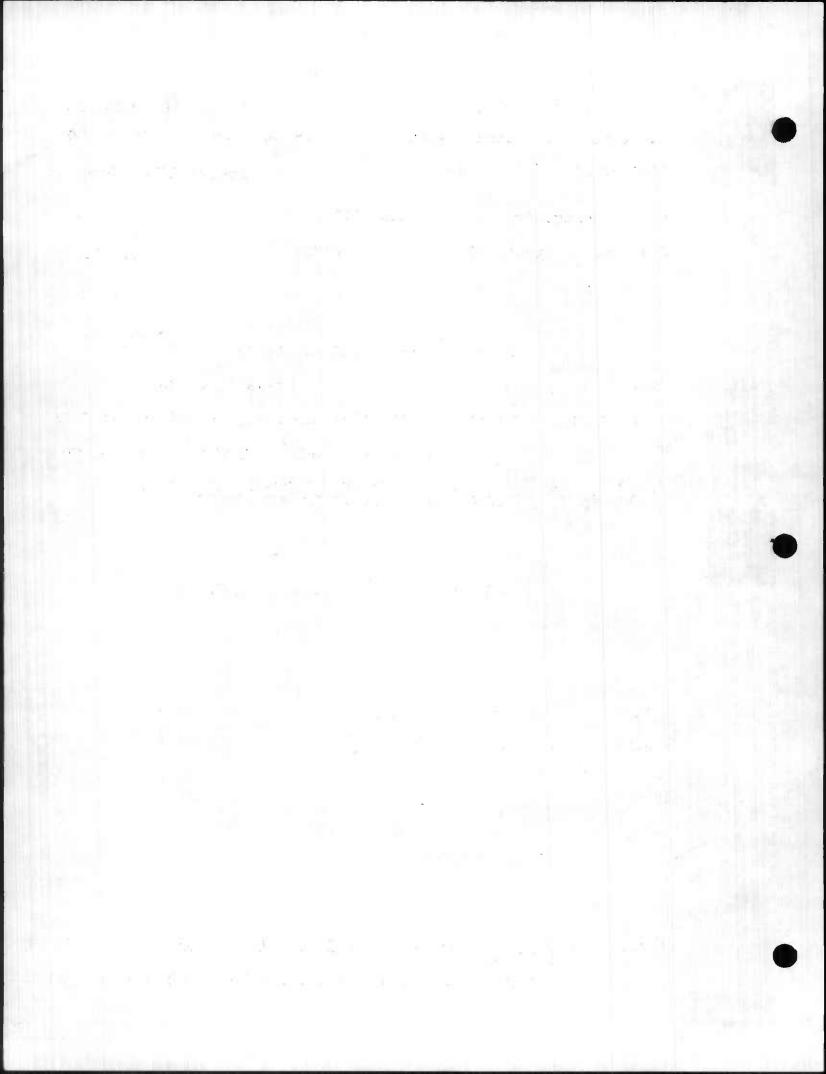
State

31. Date filed (Month, Day, Year)

MAR 1 2 1999

32. Registrer's Signature

. Sparks



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 1:30 Pm Month Year **Physician** WILBAR ITENSON 1999 MAR 03 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not Institution, give street and number) 4c. County of Death Examiner NURSING HIMIS 1000ARD ELLIGOT GITY AGNES 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 212-32-4935-A 18M 20F 94 Director Usuel Residence of Decedent 10c. City, Town or Location 10a Stete 10b. County 10d. Inside City Limits ¥ Yes 2□ No Howard Columbia Director Md 28a-f 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 8 U.S.A. 6956 Knighthood Lane, 21045 Berns 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Merried 2 ☐ Merried 8 21215-0020 1 Yes 2 No Specify: Specify: Black 3 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Gardner Home & Garden 6th Grade Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe any injury or other traumatic event, 2008. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sally Nelson Eugene Henson 19e. Informent's Neme/Reletionship (Type, Print) (Neice) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6956 Knighthood Lane, Columbia, Md 21045 Christine Fields 20b. Place of Disposition (Name of cemetery, cremetory or other place)
Metro Crematory 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from Stete 3/9/99 Alexandria, Va 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name end Address of Facility Snowden Funeral Home P.A. 246 N. Washington St, Rockville, Md 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart fellural. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Due to (or as a consequence of): /Medical Immediate Cause (Finel 4 WEEKS disease or condition resulting in death) Examiner & WBEKS Due to (or as a consequence of): Sequentially tist conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last physician s the burial LEWRISNIT Box 68760. MSPIRATIUM MONTHE Physician/Medicai Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown CIMMIC USSTRUCTURE PUMMING DISUATS of Vital Records. à 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes an eutopsy performed? Completed METHERS DOMENTIN HYPGRIONSISW 1 Yes 2 No 1 ☐ Yes 2 ☐ NO Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certific. 25. Was case referred to medical exeminer?
1 Yes 2 N6 Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Shursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menney of Death 28e. Dete of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner steted. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of contil D36974 0 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) LITTLE PATURENT PARKING COLUMBIA DAVID O. NYANJON 10724

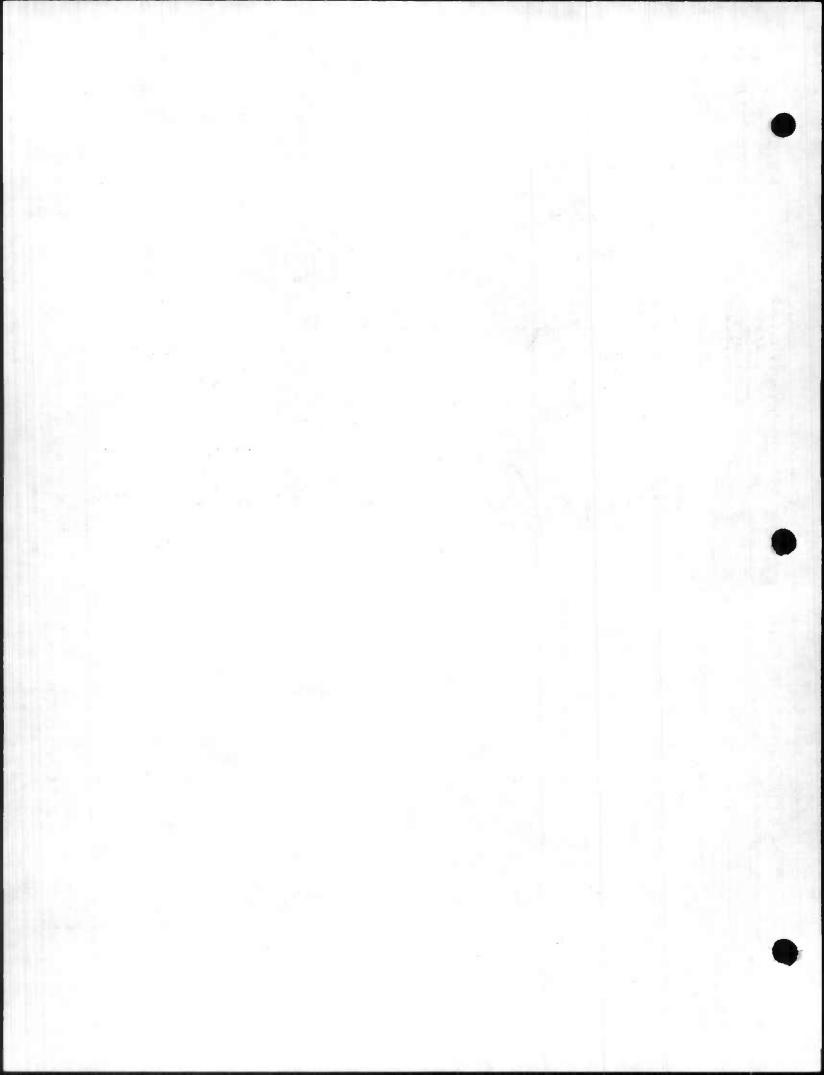
State Registrar

**DHMH 16 Rev 6/95** 

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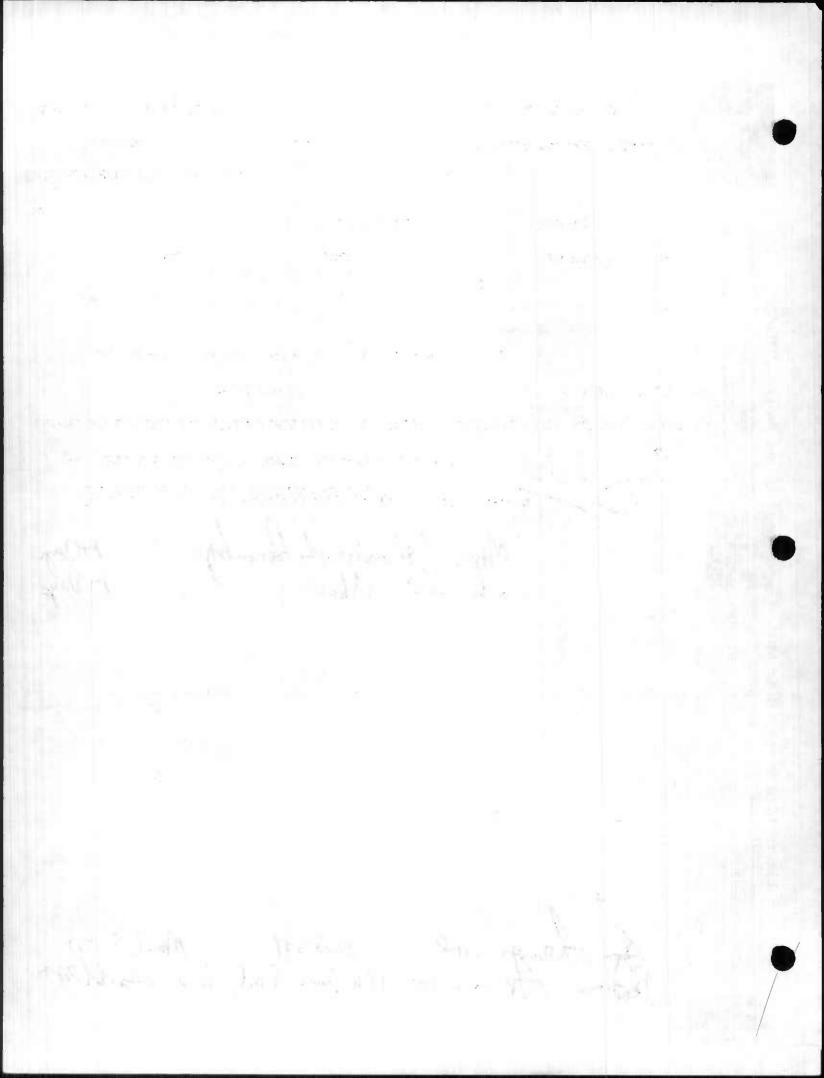
31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture souls



State of Maryland / Department of Health and Mental Hygiene

PAULINE N. HENSHALL  PAULINE N				Certifica	are or	Dealli		Reg. No.		
## Facely Neme of contribution or greater and multiple of the service and multiple of		Last)						eeth	Vaar	3. Time of Deeth
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S. Stood Secretly Number 578 S.2 748 S		AL HOSPITAL				OLNEY		MONT	COMER	Y
100   States   100   County   100   Colory   100		5. Sex 7. Age	(In yrs. lest birti			If Under 24 Hi		irth		
MONTGOMERY   STLVER SPRING   10, 2g code	578 52 7489	1□M 2⊠F	88	rs. Month	is Deys	Hours Mil			WASH	INGTON, DC
100   100	10e. State 10b. County		10c. City, Town	or Location					11	0d. Inside City Limits
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Type College   Type   College   Type   College   Type   College   Type	10e. Street and Number		OIDV					10g. Citizen of	Whet Coun	try?
Specific Notice   Comparison	15021 CANDOVER C	·T		-	20906			AZII		
Telegraphic	11. Marital Stetus	12. Wes Decedent E	ver in U,S.			Hispenic Origin?	Specify Yes or N			
15. Decidents Expected on Microsoft Specific Considered (Specify only highway great completed)  [Specify only highway great	1 Never Married 2 Married	d 1 Tes 2 TN	0				erto Rican, etc.)			
College (1-dor 5+)   College	A		160	Decedent's H	ougl Occur	nation		16h Kind at 6	Queinace/Inc	luetor
CLASSIFIED SALES REPRESENTATIVE NEWSPAPER     17. Fether's Name (First, Middle, Last)     17. Fether's Name (First, Middle, Last)     18. Molher's Name (First, Middle, Last)     18. Molher's Name (First, Middle, Last)     19. Mailing Address (Street and Number of Plausif Name Plausifonchip (Type, Print)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     18. Molher's Name (First, Middle, Maiden Summena)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     19. Mailing Address (Street and Number of Plausifonch Number of Plausifonch Number, City or Town, State)     19. Mailing Address (Street and Number of Plausifonch Number, City or Town, State)     19. Ma				(Give kind of I	work done	during most of w	orking	166. Kind of t	DUSTRICESTRIC	oustry
18. Mother's Neme (First, Middle, Last)   18. Mother's Neme (First, Middle, Maiden Sureme)   19. Mother's Neme (First, Middle, Maiden Sureme)   19. Mother's Neme (First, Middle, Maiden Sureme)   19. Maining Address (Street and Number of Number of Town, State, 2p Code)   19. Maining Address (Street and Number of Number of Path Number, City or Town, State, 2p Code)   14.305 COLONEL CLAGETT CT., UPPER MARLBORO, MD 20772   20. Method of Disposition (Neme of Kathurian (Specify)   20. Path (Specify)   20. Design of Disposition (Neme of State All Donolidon   5   Other (Specify)   20. Path (Specify)   20. Design of Disposition (Neme of State All Donolidon   5   Other (Specify)   20. Design of Disposition (Neme of State All Donolidon   5   Other (Specify)   20. Design of Disposition (Neme of State All Donolidon   5   Other (Specify)   20. Design of Disposition (Neme of State All Donolidon   5   Other (Specify)   20. Design of Disposition (Neme of State All Donolidon   5   Other (Specify)   20. Design of Disposition (Neme of State All Donolidon   5   Other (Specify)   20. Design of Donolidon   20. Des	Elementary/Secondary (0-12)		+)				CENT ATT T	ME MIEUC	DADED	
Series and Authority (Type, Print)   19b. Mailing Address (Street and Authority or Rural Route Number, City or Town, State, Zo Code)   14 305 COLDNEL CLAGETT CT., UPPER MARLBORD, MD 20772   20c. Method of Disposition   3/Permovel from State   1/20 certifier	17 Fether's Neme /First Middle I s		CILA	SOLFIEL	) SAL					
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code)  ESTHER FRANCES HALL/ DAUGHTER 20b. Method of Disposition  **Disposition**  **Disp		ast/						o, maideri Sunte	1110)	
ESTHER FRANCES HAIL/ DAUGHTER  20e. Method of Disposition (Name of KDBurist 2 Circemetion 3 Date (20c. Location - City or Town, Stete ADD Place of Disposition (Name of Order) place)  ADD Place of Disposition (Name of Order) place of Disposition (Name of Order) place)  ADD Place of Disposition (Name of Order) place)  ADD Place of Disposition (Name of Order) place of Disposition (Name of Order) place of Order   ADD Place of Disposition (Name of Order) place of Order (Name of Order) place of Order (Name of Order) place of Order (Name of Order) place of Order)  ADD Place of Disposition (Name of Order) place of Order (Name of Order) place of Order)  ADD Place of Order of Order) place of Order (Name of Order) pl										
20c. Head of Disposition   The State   20c. Place of Disposition (Name of Examples)   20c. Location - City or Town, Stelle   20c. Honor of the price)   20c. Location - City or Town, Stelle   20c. Location - City										
### Suppose of Control		IALL/ DAUGHT				CLAGETT		1		
4 Doneston 5   Chemical Service Leannes   Complications that cause of the cause of		TRemovel from State				ce)	Dete	20c. Location	- City or To	wn, Stete
DANIEL SIMONS  DANIEL SIMONS  DANZANSKY—COLDBERG MEMORIAT, CHAPELS, INC. 1770 ROCKVILLE PIKE, ROCKVILLE, MD 20852  23a. Pert1. Enter the greatese, by complications that caused the deeth. Do not enter the mode of dying, such as capital or respiratory errest.  Approximate approximate pick or conditions, the cause of each line.  Due to for as a consequence off:  25a. But it conditions, if any, leading to immediate cause. Enter Underlying Cesses (Diseases or Injury cesses) (Diseases) (Diseases			KING DA	AVID MI	EMORI	AL GARD.	3/9/99	FALLS C	CHURCH	, VA
Sequentially list conditions, if any, leading to immediate case. Enter Underlying Cases (Disease or Injury Cases (Disease or Injury Cases) (Disease	Immediate Ceuse (Final								MD 20	Approximete Intervel Between
Due to (or as a consequence of):    Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    23b. Did tobacco use contribute to the cause of death	resulting in deeth)	~ //	Due to fir as a g	onsequence (	1/200	1-1001	1		1	7 Days
Due to (or as a consequence of):    Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	Sequentially list conditions, if any, leeding to immediate	b. 200	Due to (or as a o	onsequence o	d):					1
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    Pert II. Other significant conditions contribute to the cause of death		0.								
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contribute to the cause of death   1   Yes   2   No   3   Probably   4   Unkn   24e. Was an eutopsy performed?   24b. Were autopsy finding evelleble prior to completion of cause of death?   1   Yes   2   No   2   Yes   2   Yes   2   Yes   2   Yes   2   Yes   2   Yes   2	resulting in deeth) Lest		ue to (or as a or	onsequence o	ŋ:				- 1	
24e. Wes en eutopsy performed?  25e. Vas case reterred to medical evelible prior to completion of cause of deeth?  26e. Place of Deeth (Check only one)  27e. Menner of Deeth (Check only one)  28e. Deate of Injury and Injury of Injury and Injury of In	2	d d							- 3	
24e. Wes en eutopsy performed?  24e. Wes en eutopsy performed?  24e. Wes en eutopsy performed?  25e. Was case reterred to medical evelible prior to completion of cause of deeth?  27e. Place of Deeth (Check only one)  28e. Date of Injury (Month, Dey Year)  28e. Date of Deeth (Check only one)  28e. Date of Deeth (Check only	<u> </u>									
24e. Wes en eutopsy performed?  25e. Place of Deeth (Check only one)  25e. Place of Deeth (Check only one)  27e. Place of Deeth (Check only one)  28e. Place of Deeth (Check only one)  28e. Date of Injury  28	Pert II. Other significant conditions	s contributing to death bu	t not resulting in	the underlying	g cause gi	ven in Pert i.	23b. Dlo	tobacco use c	ontribute to	the cause of death
24e. Wes en eutopsy performed?  24e. Wes en eutopsy performed?  25. Was case reterred to medical exeminer?  1   Yes   2   No    25. Was case reterred to medical exeminer?  1   Yes   2   No    26. Place of Deeth (Check only one)  27. Menner of Deeth   10 Neturel   5   Pending investigation   28e. Date of Injury   28b. Time of Injury   28c. Injury et Work?  28c. Injury et Work?  28d. Describe how Injury occurred   28d. Descr							1	Yes 2000	3 ☐ Prof	bably 4 Unknow
25. Was case reterred to medical exeminer?    1									T 0.45 144	
25. Was case reterred to medical exeminer?							24e. We	s en eutopsy formed?	eve	eileble prior to
25. Was case reterred to medical exeminer?									of	deeth?
exeminer?  1 Yes 2 De Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Menner of Death Neturel 2 Accident 3 Suicide 4 Homicide Could not be determined 28e. Place of Injury At home, tarm, street, tactory, office 28e. Location (Street and Number or Rural Route Number, City or Town, Stete)  29a. Certifier (Check only other) 2 Medical Examiner: On the basis of examination end/or investigation, In my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and menner as steted.  29b. Signature on title of certifier 29d. Rate signed (Month, Dey, Year)  29c. License number 29d. Rate signed (Month, Dey, Year)  29d. Rate signed (Month, Dey, Year)							1□	Yes 2 No	10	Yes 2□ No
Certifier (Check only   Physician: To the basis of examination and/or investigation.   Physician: To the basis of examination and or investigation.						28. Place of D	eeth (Check only	one)		
27. Menner of Death   10 Neture    2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Physician: To the best of my knowledge, deeth occurred et the time, deterning end menner stated.   28c. Injury et Work?   1   Yes 2   No   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town, Stete)   28t. Location (Street end Number or Rurel Route Number. City or Town,			nt 2□ER/Out	patient 3	DOA OI	her: 4 Nursing	Home 5 ☐ Res	sidence 6 🗆 O	ther (Specifi	v)
2   Accident   3   Suicide   4   Homicide   28e. Place of Injury - At home, tarm, street, tactory, office   28t. Location (Street and Number or Rural Route Number. City or Town, State)   29a. Certifier (Check only and its provided in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.   29c. License number   29d. Date signed (Month, Dey, Year)   29d	exeminer?	Hospitel:		panon on			-			,,
3   Suicide 4   Homicide  28e. Plece of Injury - At home, tarm, street, tactory, offica  28t. Location (Street and Number or Rurel Route Number.  City or Town, Stete)  29a. Certifier (Check only only only only only only only only	exeminer?	28e. Date of Injury	28b. T							
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated.  29d. Signature and title of cartillor  29d. Date signed (Month, Dey, Year)  29d. Date signed (Month, Dey, Year)	exeminer? 1   Yes 2   Dob  27. Menner of Deeth 1   Neturel 5   Pending	28e. Date of Injun (Month, Dey	28b. T	ijury		_				
29c. Signature and title of certified (Month, Dey, Year)  29c. License number 29d. Date signed (Month, Dey, Year)  April 908381 New L 8, 1888	25. Was case reterred to medical exeminer?	28e. Plece of Injun	Year) 28b. T	njury M	1□	_	28t. Location City or To	(Street end Num own, Stete)	nber or Rure	I Route Number.
1 Sp. Abriga , ml. 208381 Nout 8. 1999	25. Was case reterred to medical exeminer?  1  Yes 2	28e. Date of Injunt of the led 28e. Place of Injunt being building, etc.  Physician: To the basis of uniform of the led 28e. Place of Injunt building, etc.	y Year) 28b. T In	m, street, tact	1 Cory, offica	Yes 2 □ No	City or To	own, Stete) e cause(s) end n	nenner es si	teted.
30. Nems and person who corpolated cause of death (Item 23e) grype, Print).	exeminer?  1	28e. Date of Injunt of the led 28e. Place of Injunt being building, etc.  Physician: To the basis of uniform of the led 28e. Place of Injunt building, etc.	y Year) 28b. T In	m, street, tact deeth occurre	ory, offica	Mes 2 □ No	City or To	e cause(s) end n	nenner es si a, end due to	teted. o the ceuse(s)
30. Nemo an Andreas of person who convoleded cause of death (Item 23e) (Type, Print)	25. Was case reterred to medical exeminer?  1 Yes 2 Do  27. Menner of Deeth Deeth Accident 5 Pending investigal 3 Suicide 6 Could no determine  29a. Certifier (Check only 2 Medical Exemine)	28e. Date of Injunt of the led 28e. Place of Injunt being building, etc.  Physician: To the basis of uniform of the lasts of uniform of the last of th	y Year) 28b. T In	m, street, tact deeth occurre	ory, offica	Mes 2 □ No	City or To	e cause(s) end n	nenner es si a, end due to	teted. o the ceuse(s)
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	25. Was case reterred to medical exeminer?  1   Yes   7   100  27. Menner of Deeth 1   Neturel   5   Pending investigat 3   Suicide   6   Could no determine  29a. Certifier   100   Check only   2   Madical Ex	28e. Date of Injunt of the led 28e. Plece of Injunt building, etc.  Physician: To the best of uniminer: On the basis of and menner stat	y Year) 28b. T In	m, street, tact deeth occurre	ory, offica	Mes 2 □ No	City or To	e cause(s) end n	nenner es si a, end due to	teted. o the ceuse(s)

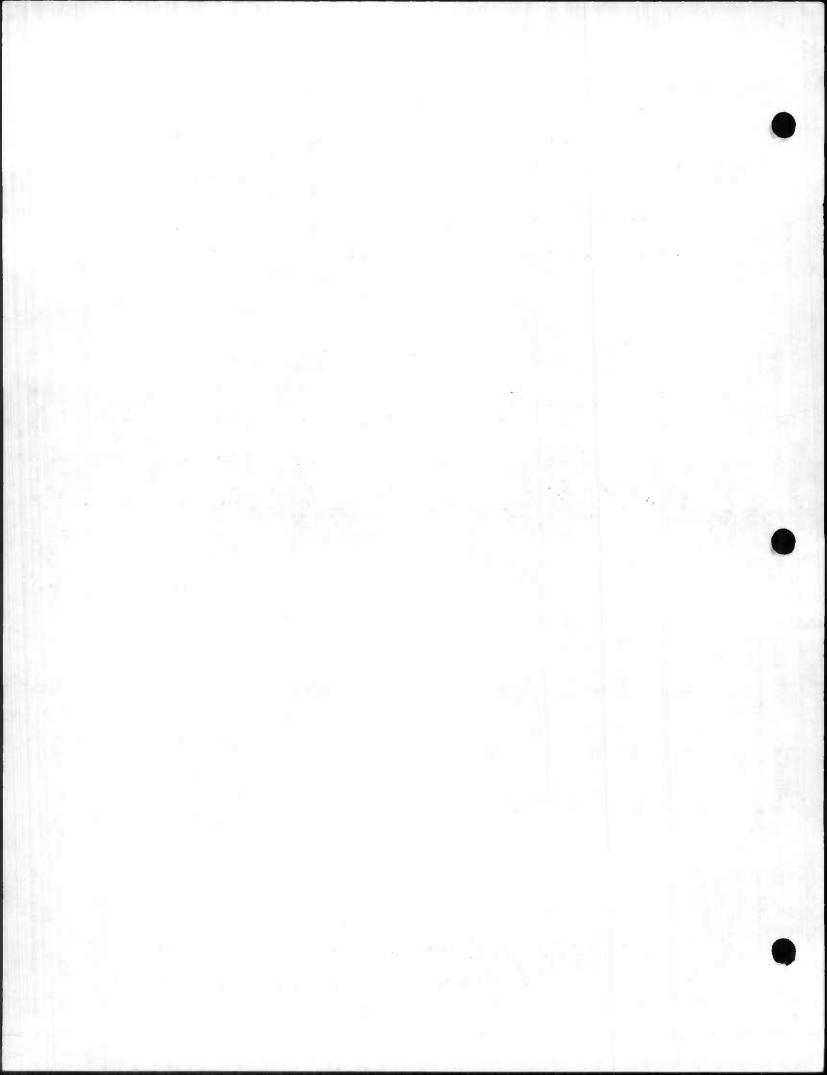


State of Maryland / Department of Health and Mental Hygiene 99 09183

Certificate of Death

					C	ertifica	ate of	Death			Reg. No.	3 0	9100
		1. Decedent's Neme (First, Midd	le, Last)							2. Dete of De	eth		3. Time of Death
Physic /Med		Jeanne Thibade	au Herlong							Month	9. 1999	Year	5:45 pm
Exam		4a Fecility Name (If not institution	n, give street and numbe	er)				4b. City, To	own, or L	ocation of Deel	,	y of Deeth	
		4502 Cheltenha	m Drive					Bethe	esda		Mont	gomer	v
Funera		5. Social Security Number	6. Sex 7. /	Age (In yrs.	last birthda		ler 1 Year	If Under	24 Hrs.	8. Date of Bi (Month, De		-	place (State or Foreign ntry)
Director		220-26-4490 Usual Residence of Decedent	1□M 2ØF	71	Yrs.	Month	s Days	Hours	Min.	May 24			ington D.C.
2 1-		10a. Stete 10b. County		10c. Cit	y, Town or	Location						1	I Od. Inside City Limits
with the Marylan a or 28e-f show be notified at	ctor	Maryland Montg	omery	Bet	hesda	a							1 ☐ Yes 2 No
har death with the r Herre 23e or 21 kiner mast be no	al Directo	10e. Street and Number 4502 Cheltenha	n Drive				7 Code 0814				10g. Citizen of United		
des des	Funeral	11. Meritel Status	12. Was Deceder	nt Ever in U,	S. 1:	3. Wes Dec	cedent of I	tispanic Or	rigin? (Sp	ecify Yes or No Rican, etc.)	o- 14. Ra	ce - Americ	can Indien,
5-0020 72 hours after natural, or to	by Fu	1 Never Merried 2 Mar 3 🖫 Widowed 4 □ Divorced	If Yes Give					Specify:		ritoan, atc.,	Specia		
	Completed	15. Deceder (Specify only highs	it's Education st grade completed)		16a. De	pedent's Us	sual Occup	pation during mos	st of work	ing	16b. Kind of E	usiness/In	dustry
2121 within sens.	dmo	Elementary/Secondery (0-12)	College (1-4o	r 5+)		stere					Siblev	Memo	rial Hospital
D BEE		17. Father's Neme (First, Middle,		Teal	INC 61	beere	d Ital	T	er's Nem	e (First, Middle	, Maiden Sume		IIII IBOPICE
and by a second	o Be	Richard Baxte	r Thibadeau					Mari	io F	Lizabet	h Nies		
should market	F	19e. Informent's Neme/Reletions			10b Me	ilina Adden	neo /Ctrani				er, City or Town	State 7ii	Code)
and 2 she path and n 27 is me or traum		Marianne Herl		ter)		-					Maryland		
Health Health Health Hem 27		20a. Method of Disposition		20b. P	lace of Dis	position (N	lame of	201		Dete	20c. Location	- City or Ti	own, State
Baltimore, semit. Pages 1 ar bepartment of Hea montant: If New 2 my Injury or other files.		1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (5		0		Heave			у 3	/13/99	Silver	Sprin	ng, Maryland
Balt permit. Depart import any in		21. Signeture of Funeral Service	4	00056		Rapp	Fune		Servi	ices, P		Manus	land 20010
-		23a. Pert1. Enter the disease, or shock, or heart failure. List		00956 ed the deat	n. Do not e	enter the m	ode of dvi	AVEIIU	cardiec	or respiretory	Spring,	Mary	land 20910
Dhysisian		shock, or heart failure. List	only one cause on each	line.									Intervel Between Onset end Death
Physician /Medical	в	Immediete Cause (Final											
Examiner		disease or condition resulting in death)	a Brain	Metas	tasis	3						1	3 months
	1	110000		Due to (o	r as a cons	sequence o	f):					1	
pel led	nju.		b. Lung (	Cancer									6 months
. Box 68760, death certificate be executed estending physician and of for use as the burial-transit	i Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury		Due to (o	r as a cons	equence o	f):					6	
68760, fficate be exa g physician a	edicai	that initieted events resulting in death) Last	С.	Due to (or	as a cons	equence of	n):					1	
Box outilization attending for use a	96		d		V.	22.2						1	
Box eath cer attendir	ciai	D . 11 D . 1 15								1			
P.O.	Physician/	Part II. Other aignificant condition	ons contributing to death	but not rest	itting in the	undenying	j cause gr	ven in Pert	1.	-			o the cause of death?
	by Pi									112	Yea ZUNo	3   Pro	bably 4 Unknown
rd Sign	B										an eutopsy	24b. W	ere autopsy findings
Vital Records, sician: The law requires to certificate has been signed rector, page 2 should be or	Completed									perf	ormed?	00	reilable prior to empletion of cause deeth?
I Rec	E										Yes 2 No		
Ecate 7.		of W							-			111	☐ Yes 2☐ No
ysician: The	Be	25. Wes case referred to medica examiner?	Hospital:				Ott	hor		h (Check only			
the side	10	1 Yes 2 No	1 LJ Inpa		28b. Time	ient 3 (	JUA	4UNI	ursing Ho		idence 6 Ot		fy)
E & §§	0	1 X Netural 5 Pendir		ay Year)	Injury	1	28c. Inju Wo		INIo	200. 10050100	how injury occu	1160	
Vision Attending or death. ector: After by the fune	cat	2 Accident investi 3 Suicide 6 Could	not be	1		М		Yes 2	NO				
Division or Attending after death. Director: After d in by the fune	Certification:	4 Homicide	ined 288. Place of I	njury - At ho etc. (Specif)	me, ferm,	street, fect	ory, office				(Street end Num wn, Stete)	ber or Run	al Route Number,
phtai Surs Surs Filled		29a. Certifier 1X Certifyin	Dhusisian Talka base	A = 6 = 1 =	4-4 4-	-40-	d =4 M = 12		-1-1				
DIVISIO To the Hospital or Attendit within 24 hours after death. To the Funeral Director; A completely filled in by the t	edicai	(Check only 2   Medical one)	g Physician: To the bes Examiner: On the basis and manner:	of examinat	ion and/or	investigation	on, in my o	opinion, des	eth occur	red at the time,	, dete and place	and due t	o the cause(s)
of the comp	Me	29b. Signature end title of certifie			4	2	9c. Licens	se number			29d. Dete sign	ed (Month,	Dey, Year)
10		· son	20 /2	Oo Po	al.	DI	5063	7			March	10.	1999
		30. Nema and address of person	who completed cause of	death /ho-	23e) (Tim						1.02.011		
(10)		Shakun M. Malik	, M.D/, 2101	l Medi	cal P		rive,	#210	), Si	llver S	pring, N	1D 20	902
St Regist	ate rar	31. Date filed (Month, Day, Year)  MAR 1 1		strar's Signal	d d	1	Day N						

DHMH 16 Ray 6/95



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12:30 AM LAWRENCE HORDES 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth ROCKVILLE ar If Under 24 Hrs. vs Hours Min. 1801 EAST JEFFERSON STREET #601 MONTGOMERY If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth MAY 3, 1904 6. Sex 9. Birthplace (State or Foreign 1♥M 2□F Months Days NEW YORK 101 32 6273 94 Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA STREET 1801 EAST JEFFERSON #601 20852 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2√2 Married WHITE 1 ☐ Yes XX No Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) NEW YORK Elementery/Secondery (0-12) College (1-4or 5+) TEACHER/RABBI PUBLIC SCHOOLS 5+ 17. Falher's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) LOUIS HORDES BESSIE GOODMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JULIET HORDES/WIFE 1801 EAST JEFFERSON STREET#601ROCKVILLE.MD 20852 20b. Placa of Disposition (Neme of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 Remove from State OLD MONTIFORE CEMETERY 3/10/99 SPRINGFIELD, NEW YORK 4 □ Donation 5 □ Other (Sp) cify) 21. Signature of Funeral Se 22. Name and Address of Fecility DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death Immediate Gause (Final ARTERIOSCLEROTIC HEART DISEASE 20 YEARS disease or condition resulting in deeth) Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown DIABETES MELLITUS TYPE 2 1 Yes 2(XNo

**Physician** /Medical Examiner

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physician

attending ō

signed by the at d be datached for

peed

has page 2

certificate

this funeral

Aftar

death.

To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

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Box 68760

P.O.

Records,

Division of Vital Attending Physician:

the death cartificate

**Physician** 

/Medical

10a. State

Director

Funeral

by.

Completed

Be 2

Examiner

Physician/Medical

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Completed

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2

Certification:

Medical

Examiner

**Funeral** 

Director

7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours aftar to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or item any injury or other traumatic event.

Baltimore, Maryland 21215-0020

tha Maryland

with

death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

24e. Wes en autopsy performed?

26. Piece of Death (Check only one)

24b. Were autopsy findings eveilable prior to completion of cause of death?

1 Yes X No

1 □ Yes 2 □ No

25.	Was case examiner?		to medical
		2 No	

ESSENTIAL HYPERTENSION

5 Pending investigation

6 Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dele of Injury (Month, Day Year)

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 ☐ Nursing Home 5 第 Residenca 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Street Rockville

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

27. Manner of Death

2 Accident 3 Suicide

4 Homicide

1 Netural

🗓 Certifyling Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated. 2 Medical Examinar: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of cartified

29c. License number

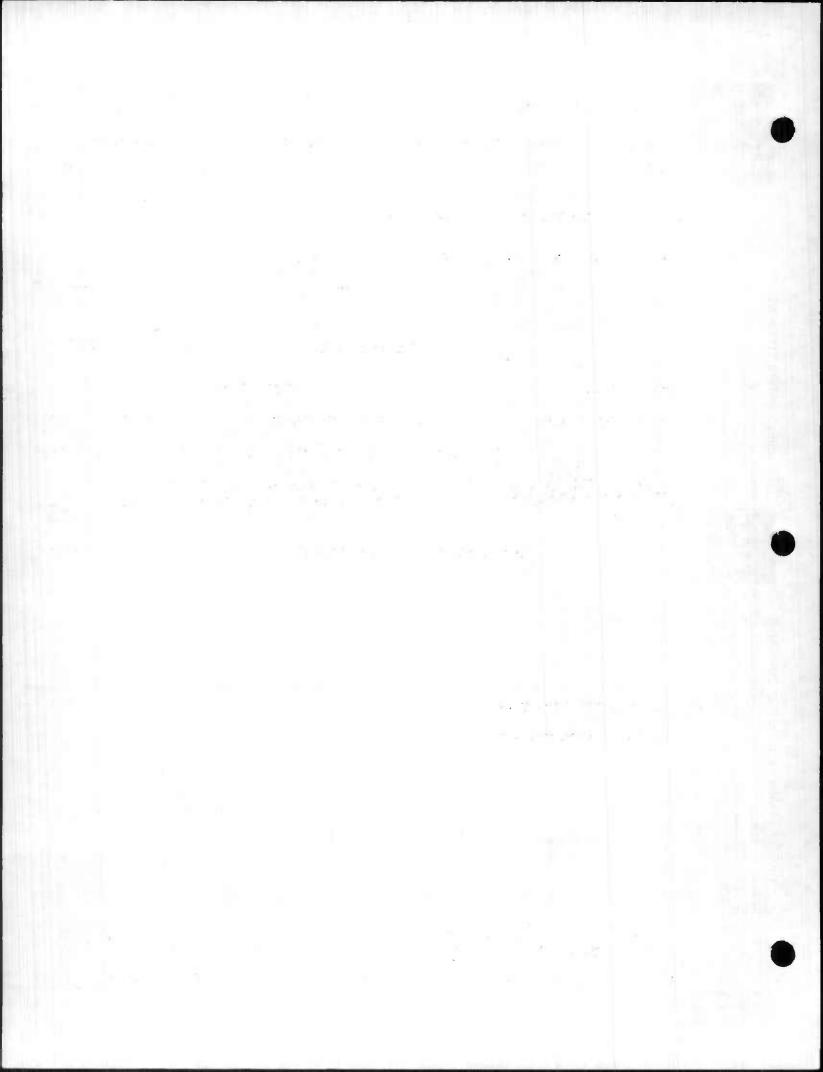
29d. Date signed (Month, Day, Year)

30. Name and address of predon who completed cause of death (Item 23a) (Type, Print)

1801 Ro

31. Date filed (Month, Day, Year) MAR 10 1999 32. Registrar's Signature

State Registrar

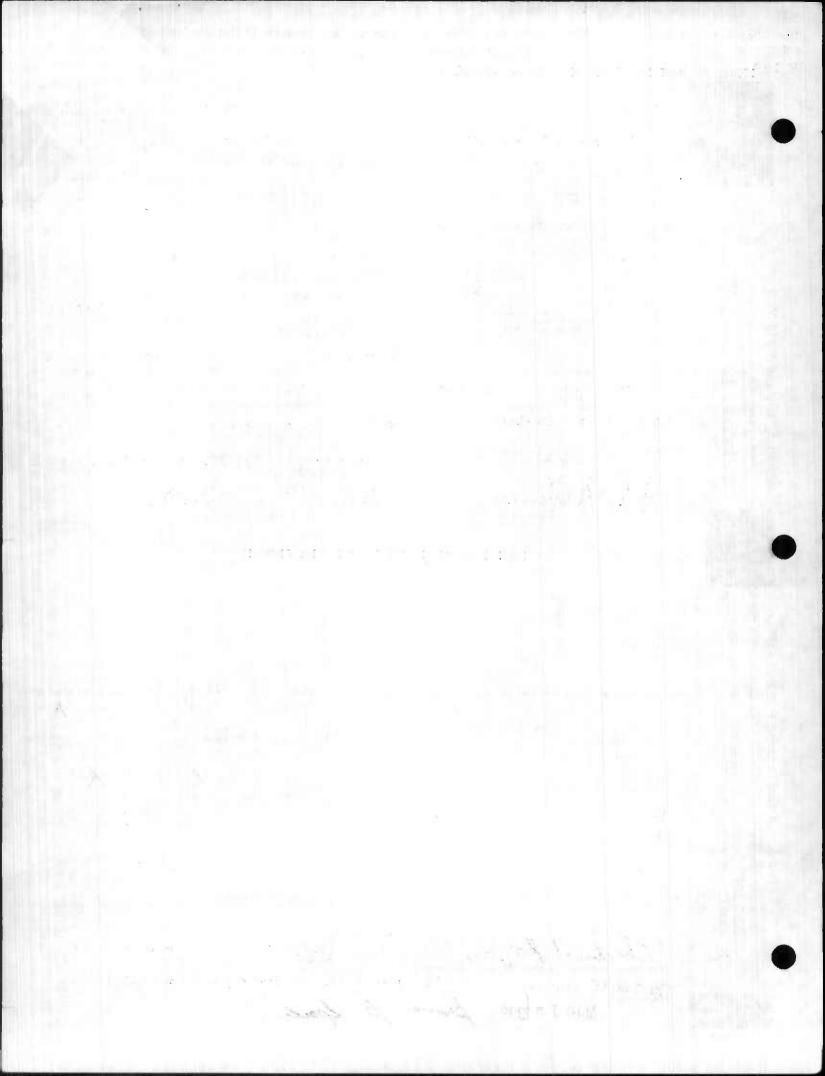


ROBERT M					State of Maryla	nd / Department of Health and Me	ntal Hygiene	0918
HAINESITEMS:	#23 PART	Ι,	27 PE	ER MEO	G772 6-30-99 WR.	Certificate of Death	Reg. No.	0310

VESITEMS: #23	PART I, 27 PER MEO G7	72 6-30-99 W	R.	Certificate	of L	Death		Reg. No.		
	1. Decedent's Name (First, Middle, Las	(1)		441			2. Date of De Month	eth Day	Year	3. Tims of Death
Physician /Medical	Robert M.	Hain	es				MARCH	06, 19		6:15 PM.
Examiner	4e Facility Neme (If not institution, give	street and number)			4	b. City, Town, or L	ocation of Deeth	4c. Count	of Death	
	KENT QUEEN ANN	ES HOSPITA	L			CHESTERI	'OWN	Ken		
Funeral Director	5. Social Security Number 6. S 214-94-1716 1 Usual Residence of Decedent	9X M 2□F 7. Age 35	) (In yrs. last b	irthday) If Under 1 Months	Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan.	th y, Year) 1,1964		olece (Stete or Foreigntry) Land
and land	10a. Stete 10b. County		10c. City, To	wn or Location					1	Od. Inside City Limits
Mary for	Maryland Queen A	nnac	0,,,,,,,,	nstown						1 ☐ Yes 2 X No
vith the Ma	10e. Street and Number	illes	Quee	10f. Zip C	Code			10g. Citizen of	What Cour	ntry?
3a o	128 Aker Road			2165	58			USA		
72-002.0 n 72 hours after deeth with the Maryland "nature!", or items 23s or 28s-f show accal Examines must be notified a leted by Funeral Director	11. Marital Status  1 Never Merrled 2 Married  3 Widowed 4 Divorced	12. Wes Decedent & Armed Forces?  1  Yes 2  N If Yes, Give Yeer or Dates:		13. Was Decede If Yes, specif	ly Cube	ispenic Origin? (Sp n, Mexicen, Puerto Specify:	ecify Yes or No Ricen, etc.)			etc.
thou and the	15. Decedent's Ed		16	a. Decedent's Usual	Occupa	ation		16b. Kind of B		dustry
	(Specify only highest gra	de completed)		(Give kind of work life. DO NOT use	done d	luring most of work	ring			
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should be made in many	19a. Informant's Name/Relationship (7	ype, Print)	19	b. Mailing Address (	Street o	and Number or Rui	ral Route Numb	er, City or Town	, Stete, Zip	Code)
and 2 saith a n 27 is	Anna Haines (	nother)	1.1	128 Aker	Roa	d, Queen	stown, M	aryland	2165	8
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Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	8.		A DUE TO MYO	CARD	IAL FIBROS	IS	- 10	1	Onset end Death
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certificate has rector, page 2	25. Was cese referred to medical					26. Plece of Dee			/	7.00 20.00
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ithin outh	29b. Signature and title of certifier	and the state of the		29c.	License	e number		29d. Date sign	ed (Month,	Day, Year)
- s - o	Theodore M.	Kit us				O.C.M.E		MARCH	08, 1	.999
	30. Name and address of person who of			(Type, Print) Penn Stre	eet,	Baltimo	re, Mar	yland 2	1201	

State Registrar 31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 9 9 186

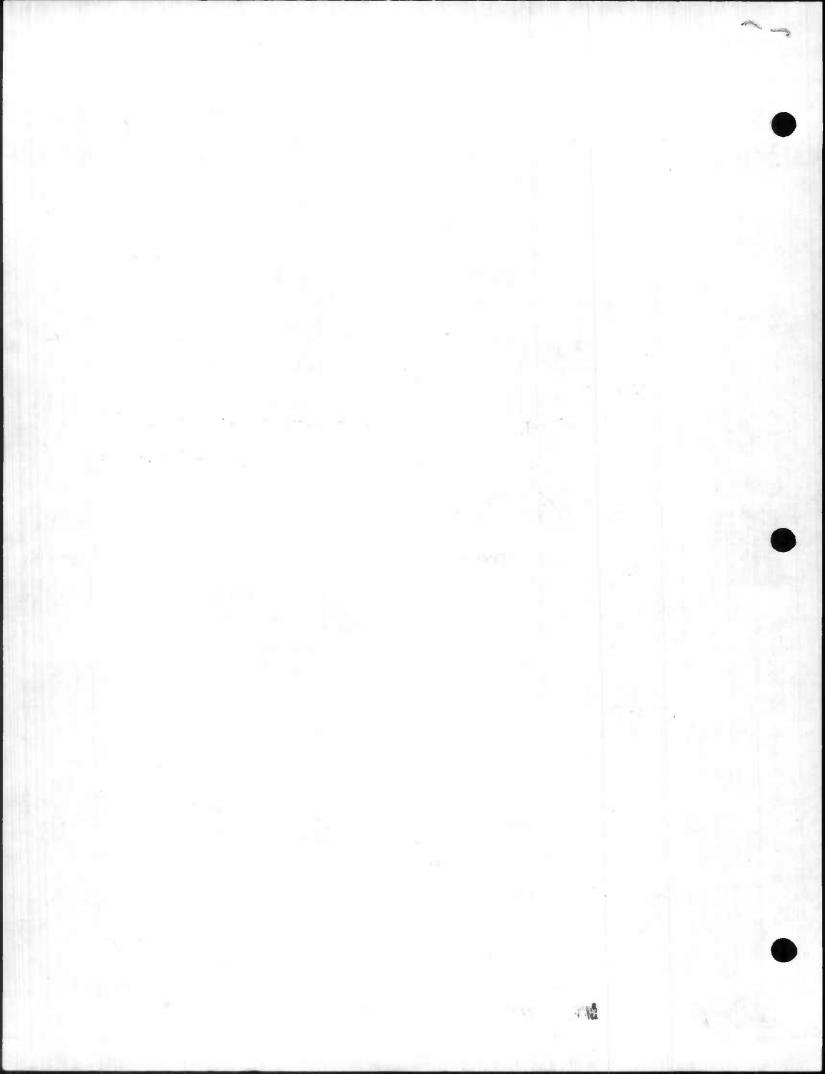
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	Exami		4a. Facility Name (If not institution, given SHORE NURSING & 1		N CENTE	CR.	4b. City, Town, or DENTON	Location of Death	, , , , , ,	of Death	
	Funeral Director		5. Social Security Number 8. S 222-01-6253 Usual Residence of Decedent	7. Aga (In y	vrs. last birthday, Yrs.	If Under 1 Ye   Months   Da		8. Date of Birt (Month, Day APRIL ]	y. Year) [2, 191	9. Birthp	place (State or Foreign http:) ELAWARE
	the Maryland 28a-f show notified at	Director	10a. State 10b. County	ALBOT 10c.	City, Town or L	ocation TON 10f. Zip Coo	la		10g. Citizen of V		0d. Inside City Limits  Y Yes 2 □ No
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lan	ed at b	To Be		MITH			AMANI				
Maryland	d2 sh th end 7 is m traum	-	19a. Informant's Name/Ralationship ( DEBORAH H. MORTO				set end Number or Ru			Stete, Zip	Code)
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. Bo	daath ce	icia	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	inderlying cause	given In Part I	23b. Did t	obacco usa co	ntribute to	the cause of death?
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of	Physician: this certific ral diractor,	70	1□ Yea 2D No		ER/Outpatie	nt 3LI DOA		lome 5 Resid			у)
n		lon	27. Magner of Death   Natural 5 Pending	28a. Date of Injury (Month, Dey Year	28b. Time of Injury		njury et Work?	28d. Describe h	now injury occur	red	
Division	leatt or:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined		t home, farm, st		T Yes 2 No	28f. Location (S City or Tox	Street and Numb vn, Stete)	er or Rura	al Routa Number,
	To the Hospital or Att within 24 hours effar of To the Funeral Direct completaly filled in by	edical C	29a. Certifier (Check only one)  29 Medical Exam	yaiclan: To the best of my land manner stated.	knowledge, deet ination and/or in	th occurred at the	e time, date and place ny opinion, death occu	, and due to the or rred at the time, o	ceuse(s) end ma date and place,	end due to	lated. the ceuse(s)
	within 2 To the I	M	290. Signature end fille of country	all "	20	B	ense number 35284	7	29d. Date sign	99	
			30. Name and address of person who	completed cause of deeth (I	tem 23a) (Type,	Priot) N. U	Washingi	fon St	East	in m	102/1501
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State of Maryland / Department of Health and Mental Hygiene

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Funera Birecto		5. Social Security N 227-14-	1240	Sex 7	. Age (In yrs. li 75	est birthday) Yrs.	If Under 1 Months I	Yaar Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bi (Month, Di 02-17-			9. Birthple Countr Virgi	inia	or Foreign
pu *		Usuel Residence o	10b. County		10c. City	, Town or Lo	cation						10	d. Inside Ci	Ity Limits
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Baltimore, N permit. Pages 1 end Department of Heelth Important: If item 27 any Injury or other tr		21. Signature of Fu	peral Service Licer	960	vaq			r-S	ss of Facility St anders & 3544. Ra		3 Fu	neral	HOme	s, PA	-
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deta deta	4	COPI								113	Tas	2∐ No	3 Probe	ably 4	Unknown
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DIVISION Of VITAL Re to the Hospital or Atlanding Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page	Medical Certification:	27. Menner of Deat  1 Oratural 2 Accident	5 Pending investigation	0.0	Injury Dey Year)	28b. Time of Injury	M 280	North	y at k? Yes 2 □ No	28d. Describe	how inj	ury occurre	bd		
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To the Hospital or A within 24 hours afrect To the Funeral Direct completely filled in b	edical	29e. Certifier (Check only one)	Certifying Ph 2 Medical Exam	ysician: To the basend menne	is of examineti	vledge, deeth ion end/or inv	occurred et vestigation, in	the tim	ne, dete and place, pinion, deeth occur	and due to the red et the time	cause( date er	s) and mar nd placa, a	nner as sta nd due to l	ited. the cause(:	5)
To the comp	Σ	29b. Signature and					29c. L	icens	e number				(Month, D	lay, Year)	
		) M.	had S.	Rulm	en us		1	2/	7106		3,	110/	79.		
		20 Name and adds	ace of pareon who	nompleted cause	of donth (Itom	23a) (Type,	Drint								
		MICE	HAEL S	RUDI	MAN,	M.	0	m	DDLETO	nell de	C>	217	69		
St Regist	tate trar	31. Date filed (Mon:	th, Day Year 1	1 1999 N	istrer's Signat	ure	6.	1	hay.				,		

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 9, **Physician** Yaar Bobby Joe HAYNES, SR. 1999 8:15 AM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 229 East Fifth Street Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Aug. 23, 1939 5 Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1**∭**M 2□ F 231-52-4547 59 Yrs. Director Virginia Usual Residence of Decedent deeth with the Meryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Wedital Examiner must be notified at Maryland Frederick Frederick 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 229 East Fifth Street, Apt. 1 21701 U.S.A. Funeral 12. Was Decedent Evar In U,S.
Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - Amarican Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after a Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural, or item any injury or other traumatic event, the Wed call Examples. 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐No Specify: by 3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter Painting Contractor 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) HAYNES Ermer Gladys ROARK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donna L. Travis, daughter 10 East 16th Street, Apt. 3, Frederick, Md. 21701 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from State Frederick Memorial Park, March 11, 1999 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility
Keeney and Basford P.A. Funeral Home 21. Signature of Funeral Servica Licanse M00255 23a. Part1. Entar the disease, or complications that causad tha death. Do not anter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 106 East Church St., Frederick, MD Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) C + - + bus1 Examiner Examiner ettending physician end for use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last c =// Physician/Medical Due to (or as a consequenca of): signed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA No No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Investigation 1 Aatural Hospital or Attending 24 hours efter death. Funeral Director: Att 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifier 29b. Signature and title of certifier. 29c. Licansa number 29d. Date signed (Month, Day, Year) P146 25 March 9, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 51 SC. VPaugh 5 501 32. Registra s Signature 31. Date filed (Month, Day, Year)

State

Registrar

AR 1 0 1999 >

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** George J. Harris Jr. March 3,1999 9:43PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death Examiner Southern Maryland Hospital Center Clinton Prince Georges If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 32 9. Birthplace (State or Foreign **Funeral** 1₩ 2□ F Months Davs Yrs. 213-32-8042 66 September 11, Maryland Director Usuel Residence of Decedent Pages 1 and 2 should be filled within 72 hours effer death with the Manyland nent of Health end Mentel Hygiene.
int: If flam 27 is marked other than "natural", or items 23a or 23a-f show any or other tranmatic event, the section to any or other tranmatic event, the section to any or other tranmatic event, the section to the section of 10d. Inside City Limits 10e State 10h County 10c. City. Town or Location Maryland Prince Georges 1 Ves 2 □ No Suitland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4691 Homer Avenue 20746 Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Self-Employed 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George J. Harris Sr. Catherine White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informent's Name/Relationship (Type, Print) Mary Neal- sister Box 72 Bryantown, Maryland 20617 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or once. ST. Marys Cemetery March 11, 1999 Bryantown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21 Signature of Funeral Service Licenses Adams Funeral Home Aquasco, Maryland 20608 23a. Pert1. Enter the Osease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Examiner physician end the buriel-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the el Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? should b 24e. Was an autopsy Completed After this certificate he funeral director, page 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Dey Yeer) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 Yes 2 No death. investigation efter deat Director: 6 Could not be To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of cartifier attenday pm)

State Registrar 31. Date filed (Month, Day, Year)

AM LY ASAN

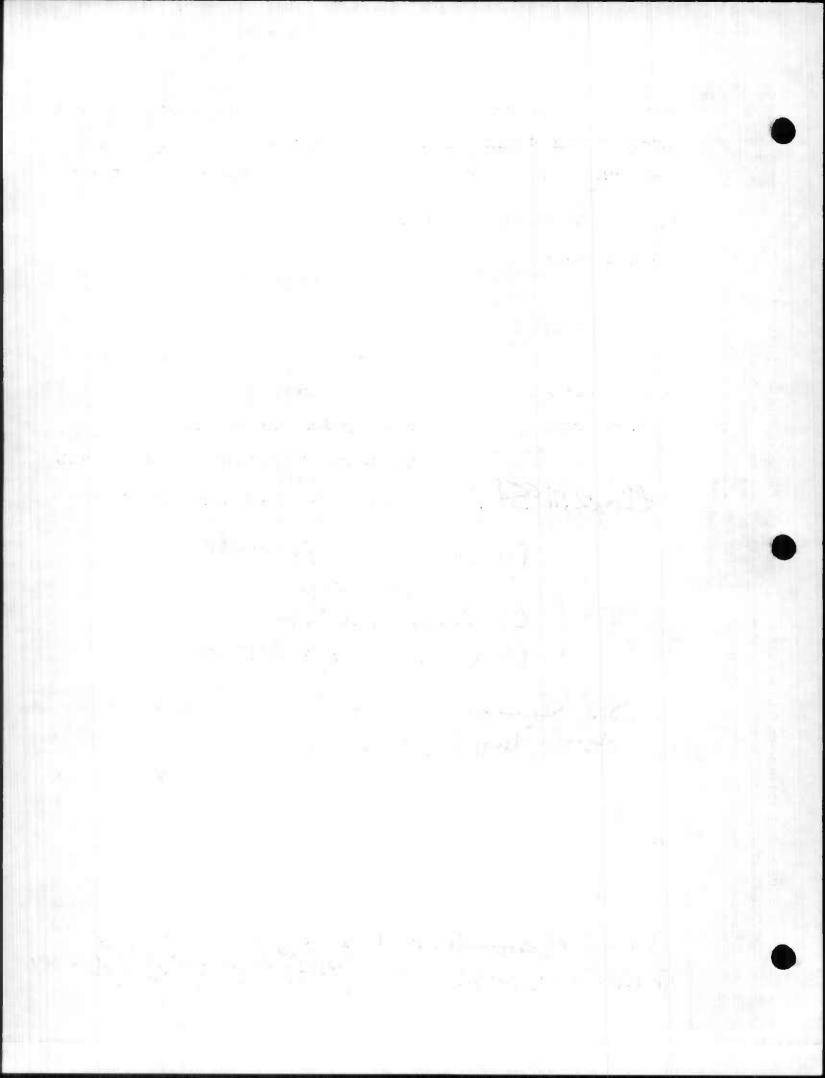
MAD 1 1 1999

32. Registrar's Signature

ANSASIMI

completed cause of death (Item 23a) (Type, Print)

B. Sparks



FOR STATE REGISTRAR 1 -

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

					107116		DEA			HEG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF MONTH	DEATH		YEAR	3. TIME OF DEATH
	MINNIE	MAE			<b>HEMB</b>	REE			Mac	1	7 1	999	8:33 P "
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. Is	est birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF	BIRTH	,		PLACE (State or Foreign
	247-34-5932	1 🗆 M 2 🗓 F	98	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, D	ey, Year) 24,19	100	Country	TH CAROLINA
	9a. FACILITY NAME (If not institution, give at	reet and number)			9h CITY	TOWN (	OR LOCATI	ON OF DE		24,13		INTY OF DE	
œ	MANOKIN MANOR	,					ESS A		D1111			OMER	
DIRECTOR	RESIDENCE OF DECEDENT				IK	TIVOI	200 E	TIATATE			3	OPILIC	DEI
E	10a. STATE 10b. COUNTY			10c, CIT	Y, TOWN O	OR LOCAT	TION						10d. INSIDE CITY
P. C.	S.CAROLINA GREE	NVILLE		1	TAYL	ORS						- 1	LIMITS?
	10e. STREET AND NUMBER	IV EBBE			111111		f. ZIP COD	E			10a CIT		HAT COUNTRY?
FUNERAL	15 TANOUTT TANE	RT 3					296					J.S.A.	
Ž	15 JANQUIL LANE 11. MARITAL STATUS	12. WAS DECEDEN	IT EVED IN ILC A	BMED	10.3	W C D T C						_	
	1 Never Married 2 Married	FORCES? 1	YES 2 X	NO		f yes, sp	ecify Cuba	n, Mexica	IIC ORIGIN? (1 n, Puerto Rici	specify Yes in, etc.)	or No—	14. RACE Black,	- American Indian, White, etc.
BY	3 K Widowed 4 □ Divorced	IF YES, GIVE V	WAR OR DATES		1	YES	2 💢 NO	Specify	<i>r</i>			Specify	
0	15. DECEDENT'S EDUC	ATION	16e. D	ECEDENT'S	USUAL OC	CHIPATIO	ON		16h Ki	ND OF BUS	INCOMINE	DUCTEY	WHITE
	(Specify only highest grade Elementary/Secondary (0-12)			Give kind of	work done o			ng	100. 10	NO OF BOS	M4E33/1141	DOSTAT	
7	6	College (1-4 or 5	"	HOME	MAKE	R				(	WN E	IOME	
COMPLETED	17. FATNER'S NAME (First, Middle, Last)			110111			10. 1107	MEDIO MAI	ME (First, Mide				
	LUTHER LOLLIS						110000				Sumame)		
BE	19a. INFORMANT'S NAME (Type/Print)								PULLE				
입	EARLINE OSBORNE								Route Number,				21849
	20s. METHOD OF DISPOSITION			5325	-			Ψ.	PARSO	_			
	1 💢 Burial 2 □ Cremetton 3 □ Remo	oval from State	20b. PLACE cemetery, cr	ematory or o	OF DISPOS ther place)	ITION (Ne	eme of		DATE	20c. LO	CATION —	City or Tow	rn, Stata
	4 Donation 5 Other (Specify)		- FORKS	HOLS	BAPT	IST	CHUI	RCH_	13-11	199 T	AYLO	RS, S	. CAROLINA
	21. SIGNATURE OF FUNDAMENTAL SERVICE LIC		10		22.1	NAME AP	ND ADDRE	SS OF FAC	CILITY				MIAN ST.
	15. Keits	1 trues	w Ct	- 2b	B	OHNI	os ei	INFRA	т. ном	F TNC			MD 21804
	23. PART I. Enter the diseases, or c	omplications tha	t caused the d	leath. Do r	not enter	the mo	de of dy	ing, suci	as cardiac	or reaple	ratory ar	rest.	Approximate
	shock, or heart failure.	list only one cau	ise on each iln	e.									interval Between
	iMMEDIATE CAUSE (Final disease or condition	0	CL			.0.	T	)	7 .	1/		07	Onset and Death
ł	resulting in death)	DUE TO	OR AS A CONS	OUENCE O	)eu		-	em	ncia	, vas	cut	as /4	of 2 chrs
_	_	Gana	0:	03	Ros	- Alle 1	0000	P:	0.0.	77		20	Onset and Death  3 yrs  5 yrs
Ó	Sequentially list conditions,	OUE TO	(OF AS A CONSE	EQUENCE OF	P:	-Se	LHO.	ue	D	1 Vas	esse	Band .	5 yrs
AT	if any, leading to immediate cause. Enter UNDERLYING				,				de	ae	ero		į į
윤	CAUSE (Disease or Injury that initiated events	DUE TO	(OR AS A CONSE	OUENCE O	Pi:						×0 0		
E	resulting in death) LAST												1
CERTIFICATION													
	PART II. Other significant conditions	contributing to	death but not	reaulting	in the un	derlying	g cause g	given in	Part I. 24	a. WAS AN			WERE AUTOPSY FINDINGS
MEDICAL	Phripheral	Vase	ulas	12	rea	po	2			PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
	andrexia.	Dele	deat	teon	· K	nes	em	And		163 2	(M) NO		OF DEATH?
	DID TOBACCO USE CONTR				€ □ N	JO [	LINC	ERTAIN					1 TYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			CE OF DEA			1 0140	FICINII					
SS	EXAMINER?	HOSPITAL:	EB/Outpetlant	2 🗆 DO4	OTHER				00.000				
¥	27. MANNER OF DEATN	28a. DATE OF		28b, TIM		28c. INJ		eldence	6 Other (S 28d. DESCR		LHIMY OC	CHRED	
	1 Netural 5 Pending	(Month, D		INJ	URY	WO	PRK7	7 NO	zea. veşcri	BE NOW IF	IJURY OC	COMED	
B	2 Accident Investigation	260 PLACE O	F INJURY — At h	4	···			NO		W. P. Woods			
	3 Suicide 6 Could not be 4 Nomicide determined	building,	atc. (Specify)	Orne, Jenni, I	street, racte	жу, отис	•		26f. LOCATIO	own, State)	nd Number	or Hural Ho	ute Number,
COMPLETED	AA CERTIFICA			_									
릴	29a. CERTIFIER (Check only one)												
8	2 MEDICAL EXAMINER	: On the basis of a	camination and/or	Investigatio	n, in my o	pinion, d	eath occur	ed at the	time, date and	l place, and	due to th	ne cause(s)	and manner as stated.
	296 SIGNATURE AND TITLE OF CERTIFIER	0					29c. LICE	NSE NUM	0ER	T	29d. DAT	E SIGNED /	Month, Day, Year)
BE	Elegera U.	Bell	2-02-0	h.	0		Di	295	05	.	<b>&gt;</b> 2	? - 0	-99
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	SE OF DEATH (ITE	ЕМ 27) (Тура,	Print)							0	
	GREGORIO M. B	ELLOS	2. MD: 5			VABO	SRR)	DR	, SAL	ISBU	CRY.	MD	21801
	MAR 0 9 1999	32. REGISTRA	R'S SIGNATURE	4	lon.	1	,						

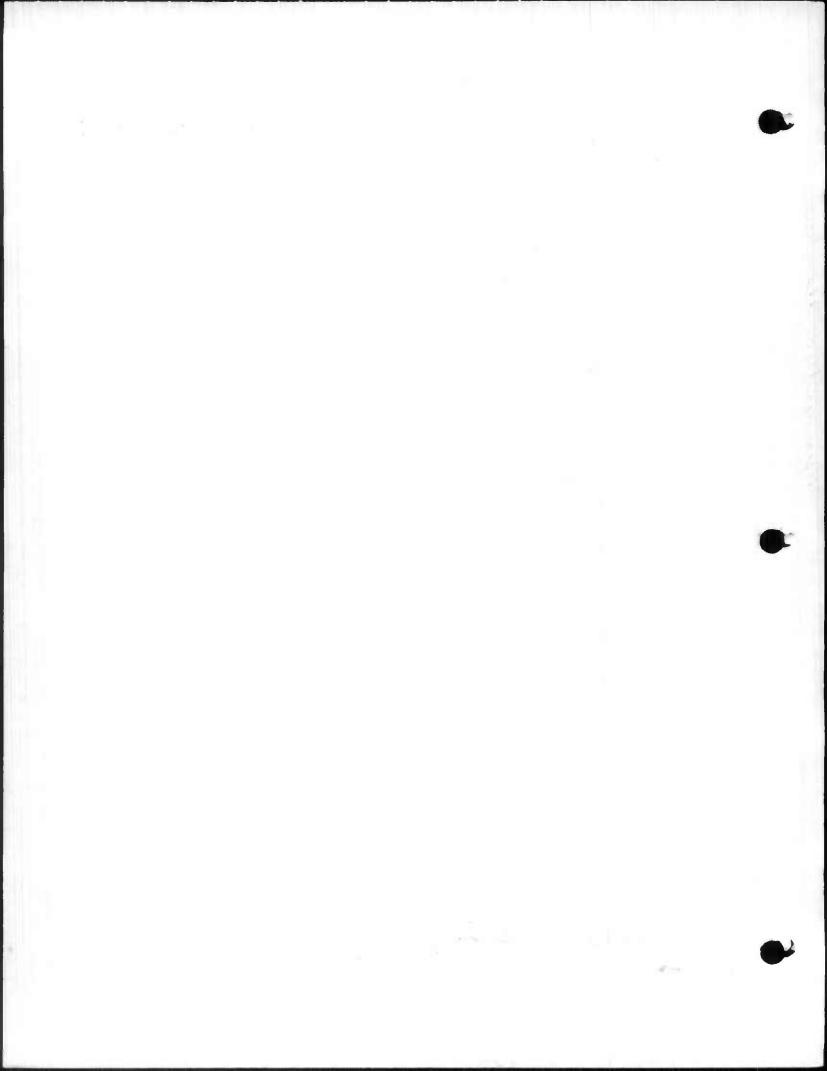
Sparks

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

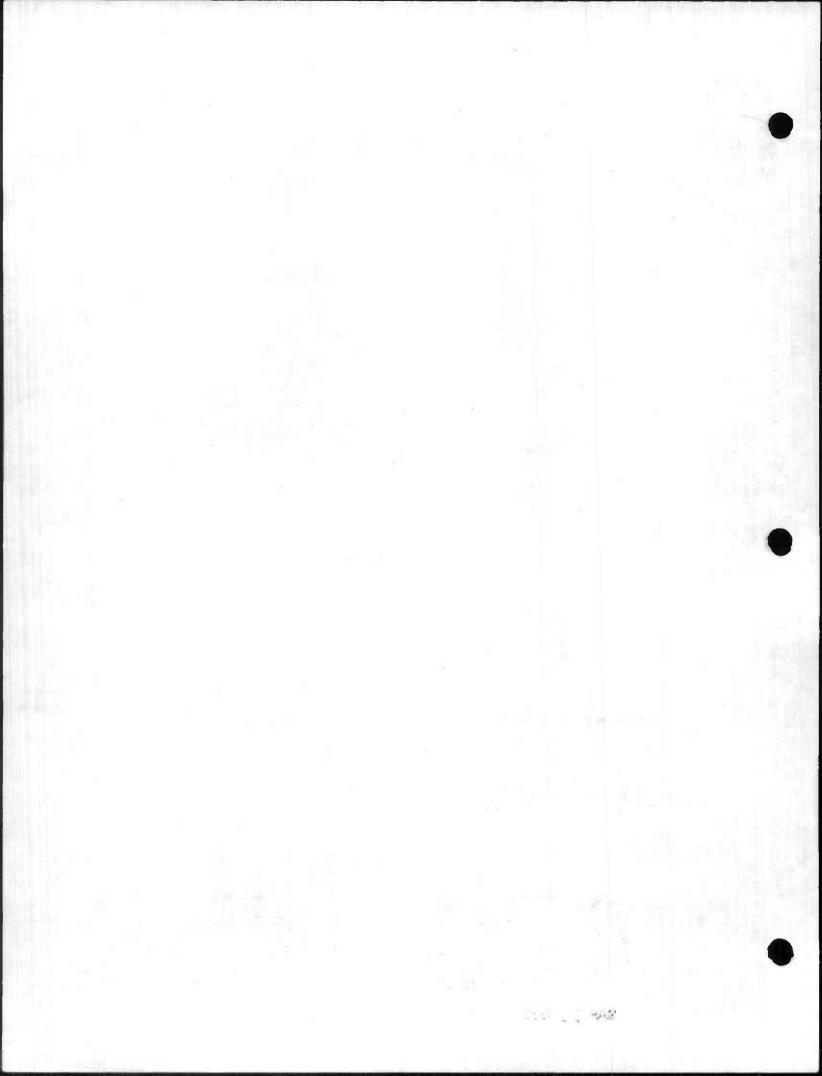
minis Mac Hambres

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.



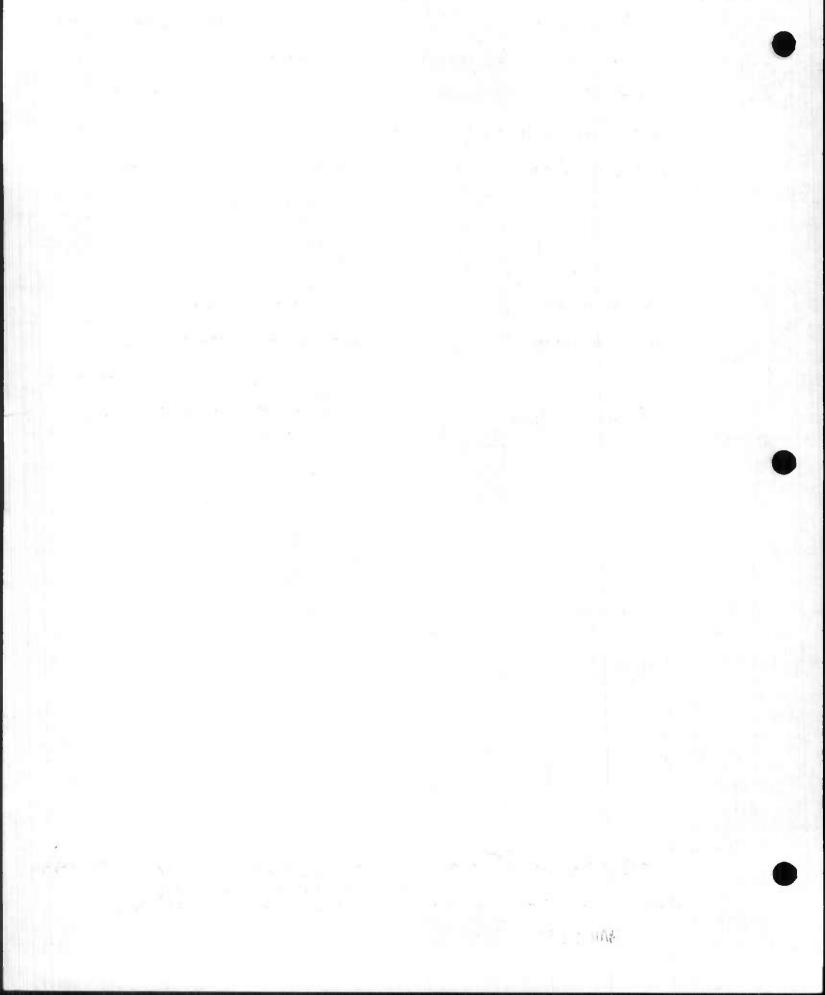
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Death 2. Dete of Death Month Day Physician Frances Goodall 10:30am March 8 1999 /Medical , 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 21XF Months 578-36-8812 90 Director June 12, 1908 Virginia Usual Rasidence of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumatic event, the Medical Examiner must be notified at MD Anne Arundel 1 Yes 2 No Director Severna Park the 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Nerns 23a or 43 West McKinsey Road, Apt. 310 21146 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ②No If Yas, Giva Yaar or Datas: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11 Maritai Status filed within 72 hours after 1 Nevar Marriad 2 Married altimore, Maryland 21215-0020 ò 1 TYas 2 X No Specify: White Specify: P 3 ☑ Widowed 4 Divorced "natural", Completed Decedent's Usual Occupation
 (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Montal Hygiena. Important: If Item 27 Is marked other than? Elementery/Secondery (0-12) College (1-4or 5+) Secretary University 17. Father's Nama /First Middle Last 18. Mothar's Nama (First, Middle, Maiden Surname) Be Joseph Goodall Lillian Bowman 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 583 Highbank Road, Severna Park, MD 21146 Landon B. Holt, Jr./ son Pages 1 20b. Place of Disposition (Name of cematary, cramatory or other place) Mar 12 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from Stata MD Veterans Cemetery Cheltenham, MD 1999 4 ☐ Donation >5 ☐ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Puperal Se Gov. Ritchie Hwy., Severna Park, MD 21146 PM I Enter tha diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition rasulting in daeth) Examiner Due to (or es a consequence of). The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaase or injury that initiated evants rasulting in death) Last and Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical eq. Dua to (or as a consequence of): 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed disease 25. Was casa referred to medical examinar? 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician:
 4 hours after death.
 Funeral Director: After this certifical
 Funeral Director: After this certifical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Panding invastigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital c within 24 hours a To the Funeral C completely filled 29a. Cartifian Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature a 29c. License number 29d. Data signed (Month, Day, Year) 8 w 30. Nama and addrass of person who usa of daath (Item 23a) (Type, Print) #302 Da 31. Data filed (Month, Dey, Year) 32. Registrer's Signetura State 1999 MAR 11 Registrar



State of Maryland / Department of Health and Mental Hygiene Amend. 20b 3/11/99 SM AACO Health Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month WILLIAM HUGHES 9 0630 /Medical 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street end number) DMEDICAL (ENTOR 4c. County of Deeth Examiner BALTIMORE BAUTIMORE CITY 6. Sex 1 → M 2 □ F 7. Age (In yrs. lest birthdey) If Under 24 Hrs. Hours Min. 5. Social Sacurity Number If Under 1 Year 8. Dete of Birth (Month, Day, Feb 10, Birthplace (State or Foreign Country) **Funeral** Days 240-18-2244 79 Director 1920 N. Carolina Usuei Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23s or 28s-f show Examiner must be notified at MD Anne Arundel 1 Yes 2 No Director Severna Park 10e. Street end Numbe 10f. Zip Code 10g. Citizen of Whet Country? 516 Bayberry Drive 21146 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, permit. Pages 1 and 2 should be filed within 72 hours effar to Department of Health and Mental Hygiene.
Important: If Itam 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examination. Black White atc 1 X Yes 2 No If Yes, Give Yeer or Detes: 1 Navar Married 2K Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: White by Specify: 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Attorney Legal 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Charles Cromwell Hughes Beulah Hodgin 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Hughes / wife 516 Bayberry Drive, Severna Park, MD 21146 MaPate 1 1 220c. Location - City or Town, Stete 20b. Pleca of Disposition (Name of camatery, cremetory or other piece)
Metro Crematory 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Baltimore, MD 1999 4 Donation 3 ☐ Other (Specify) 21. Signature of Full oral Service Histors 22. Name end Address of Fecility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 E (er the disaesa, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errast, heart failure. List only one cause on each line. Approximete Intervai Between Onset and Death Physician /Medical Immediete Causa (Final SEPSIS disaase or condition resulting In death) ONE WEEK Examiner Due to (or es e consequenca of): Examiner AURTIC VALUE ABSCESS MONTHS sician and bunal-transit The law requires that the daath certificate be axecuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Dua to (or es e consequence of) P.O. Box 68760, Physician/Medical the Dua to (or as a consequenca of) for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. by ate has been signe page 2 should be 24b. Were eutopsy findings evallable prior to completion of cause of deeth? Be Completed 24a. Wes en eutopsy parformed? certificate 1 ☐ Yes 25 No 1 Yas 2 No Division of Vital or Attending Physician: director, 25. Wes case referred to medical examiner? 28. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 25 No Certification: To Impatiant 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral ( 27. Magner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending invastigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 1 Cartifying Phyelcten: To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner steted. Medical 29a. Certifier (Check only the 29b. Signature end title of certifier 29c. Licansa number 29d. Data signed (Month, Dey, Year) Mem lon 12443 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) UMVERSITY OFMARYUAND MEDIUAL CENTER BALTIMUREMD ZIZU HEATHER MANIVUEL 22 SOUTH GREENE ST MD 31. Dete filed (Month, Pay, Year) MAR 11 1999 32. Registrer's Signature State Registrar

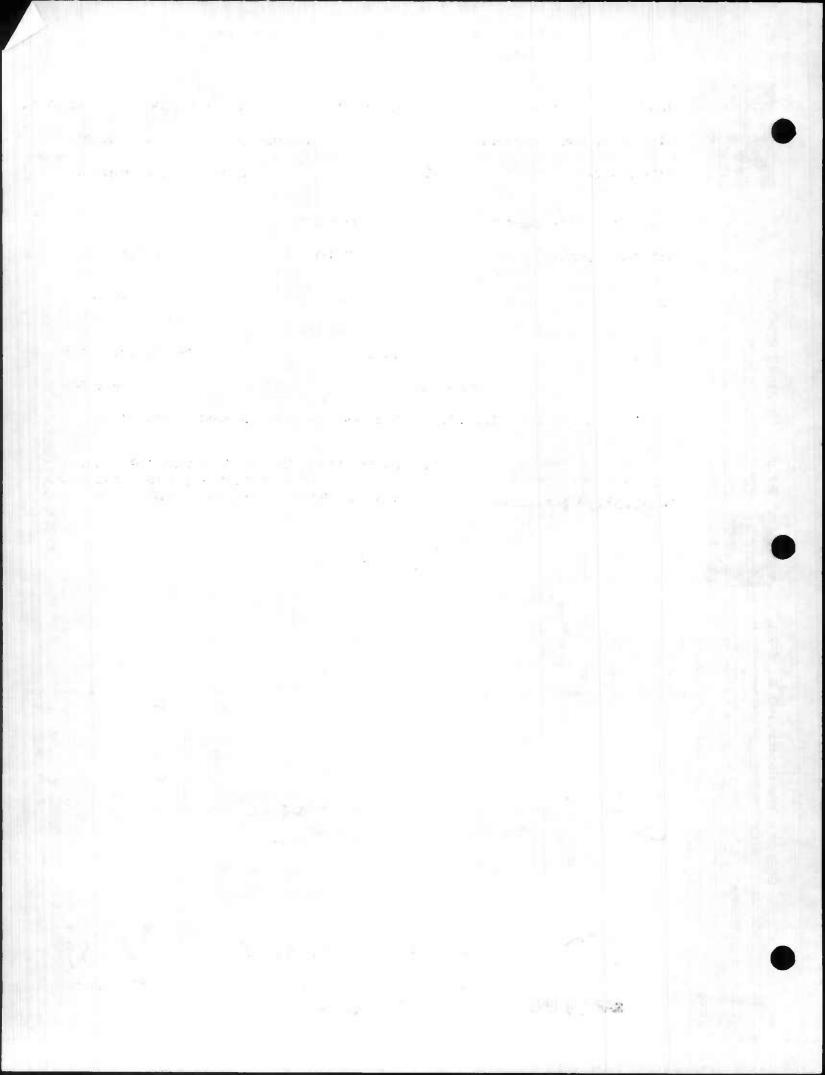
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	land		Usuel Residence of Decedent  10a. Stele 10b. Count	у		10c. C	ity, Town or Lo	cation						10d. inside City Limits
	n the Marylan r 28a-f show	tor	MARYLAND ANNI	E AR	UNDEI	ANN	APOLI	S						1 Yes 2 □ No
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	of Heaith		LEVI HERBER'  20e. Method of Disposition	1 (50	IN )	20b.	Place of Dispo	GROSS sition (Name of		1	1	Oc. Location -		
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Baltimore,	permit. Pege Department i Important: If any injury or		21. Signeture of Funerel Service					. Name and Addr			37.3,3	7 500	134414.	ER, HD.
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0,	be executed Icien and buriel-transi	Ex	Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disaese or Injury thet initiated evants					,						
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	To the Hospital or Attending Ph within 24 hours after death. To the Fureral Director: After th completely filled in by the funeral	edical C	29a. Certifler (Check only one) 12 Medical	ng Physic i Examine	ian: To the	sis of examina	owledge, deeth atlon end/or inv	occurred at the trestigation, in my	ime, dete end opinion, deeth	plece, end	d due to the ce et the time, de	use(s) end ma te end plece, e	nner as s and due t	steted. o the cause(s)
	within To the	Me	29b. Signature and title of certific	9r	0		11	29c. Licen	se number		29	d. Date signed	(Month,	Dey, Year)
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			30. Name and address of persor	who com	pleted ceus	of deeth (iter	m 23e) (Type,	Print) Za	٨ تد	yd.	cal F	kun		1 , , ,
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State of Maryland / Department of Health and Mental Hygiene 9 9 1 9 4

				Certific	cate of	Death		1	Reg. No.		
	1. Decedent's Name (First, Middle,	Last)					2	. Dete of Dee	eth	V	3. Time of Death
Physician	ANITA	MARY	н	ILLENB	RAND		M	Month IARCH	7. 199	Yaar 19	12:47 PM
/Medical	4a Facility Neme (If not institution,	give street end numi				4b. City, To		tion of Deeth	-	unty of Deeth	
Examiner	MARINER AT NOR	TH ARUNDEL					BURNI		ANI	NE ARUI	
uneral irector	5. Sociel Security Number 212–22–4624	5. Sex 7.	. Age (In yrs. lest bir	Yrs. If U	Inder 1 Year oths Deys	If Under Hours	Min.	Dete of Birt (Month, De) UNE 3	v, Year)	9. Birthy Could	place (State or Foreign http:// LAND
A III	Usuel Residence of Decadent  10e. Stete 10b. County		10c. City, Town	n or Location	)					1	10d. fnside City Limits
Director	MARYLAND ANN	E ARUNDEL			LEN BU	RNIE			10a Cilizan	of Whet Cour	1 ☐ Yes 2 ☐ No
	713 JAMES ROAD				2106	1				.S.A.	intry r
by Fune	11. Merital Stetus  1 □ Nevar Merried 2 □ Merrie  3 ፟ಔ Widowed 4 □ Divorced	12. Wes Deced Armed Forc 1 Yes 2 If Yes, Give Yeer or Date	es? XNo	If Yes,	Decedent of H specify Cubo es 2 X No	en, Mexicar	n, Puerto Ri	fy Yes or No- can, etc.)		Race - Americ Bleck, White, ecity: WHI:	etc.
	15. Decedent's (Specify only highest Elamantary/Secondary (0-12)	Education grede completed) Collaga (1-4		Decedant's (Give kind o life. DO NO	Usual Occup of work done OT use retire	during mos	t of working		16b. Kind	of Businass/In	dustry
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treumet	19a, Informent's Name/Relationshi LORRAINE A. BA									wn, Stete, Zij	
or other	20e. Method of Disposition  XX Burial 2 □ Cremetion		20b. Place of cemeter	f Disposition ry, cremetory		ce)		Date		ion - City or To	
eny injury or	4 Donetion 5 Other (Special Service L	**	HOLY F		ne end Addre	ss of Fecili	y SING	LETON	FUNER		MD. E, P.A., D. 21061
	23a. Pan1. Entar the shock, or heart f	plications that cau	used the deeth. Do not hine.								Approximata Interval Batween Onset end Deeth
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es the bunal-transit	Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Ceusa (Disease or injury that initieted events	b	Dua to (or as e								
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etached betached Physi	Pert II. Other significant condition	s contributing to deal	th but not resulting Ir	n the underly	ring cause giv	en in Pert	l.	23b. Dld 1		/	o the cause of death?
2 2								24e. Was perlo	an eutopsy med?	6/	Vere eutopsy findings vellebla prior to completion of cause deeth?
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ed in by	3 ☐ Suicide 6 ☐ Could no determin	ed Zoa. Placa o	f Injury - At homa, fa g, etc. (Specify)	arm, straet, fa	actory, office		28	f. Location (3 City or Tox		lumber or Rur	zi Route Number,
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M	29b. Signeture end title of certifier	1			29c. Licens	se number	L. 0		29d. Dete s	igned (Month,	Dey, Year)
	30. Nama end eddrass of person w	no complated causa		(Type, Print)	L L	18	508	0			7)
State	Charles Wu 31. Dete filed (Marth Psy. Year)	MO 32.76	1600S.Co	rain	Hwy	#106	Glen	Burni	e m	oau	061



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Month Day **Physician** 1999 E11a March 7, 2:00 P.M. May HERSHBERGER /Medical 4a Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haulth end Mantal Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other treumatic event, the Maryland Examinar must be notified at DDCs.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the deeth certificate be assected within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

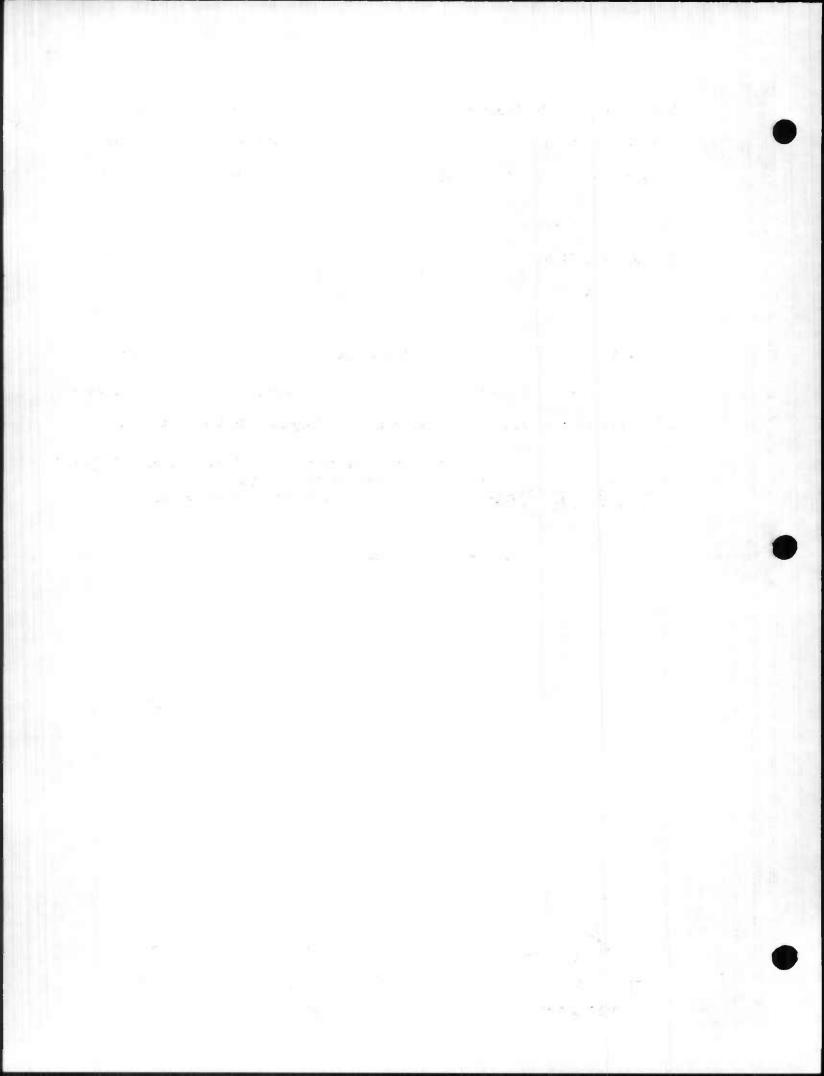
P.O. Box 68760

Division of Vital

6736 Garrett Highway 0akland Garrett If Undar 1 Yaar Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1□M 210 F 78 212-19-1414 Ohio Usual Residence of Decedent 10a State 10c. City. Town or Location 10h County 10d Inside City Limits 1 ☐ Yes 2 No Director Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21550 Funeral 6736 Garrett Highway U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 8th Housewife Home 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Malden Surname) Be Joni \_\_\_\_ Miller Lizzie Hostetler 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Atlee Hershberger/ Spouse 6736 Garrett Highway, Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 N Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Slaubaugh Cemetery 3/10/99 Oakland, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility 1 Home 32 S. Second St., Oakland, MD 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or haart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final Alzheimer's Disease years disease or condition resulting in death) Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown by 24b. Wera autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy 1 Ves 2 No 1 □ Yes 2 □ No 25. Wes case referred to medical 8 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Othar (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Naturel 2 ☐ Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homleide 1K Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated.

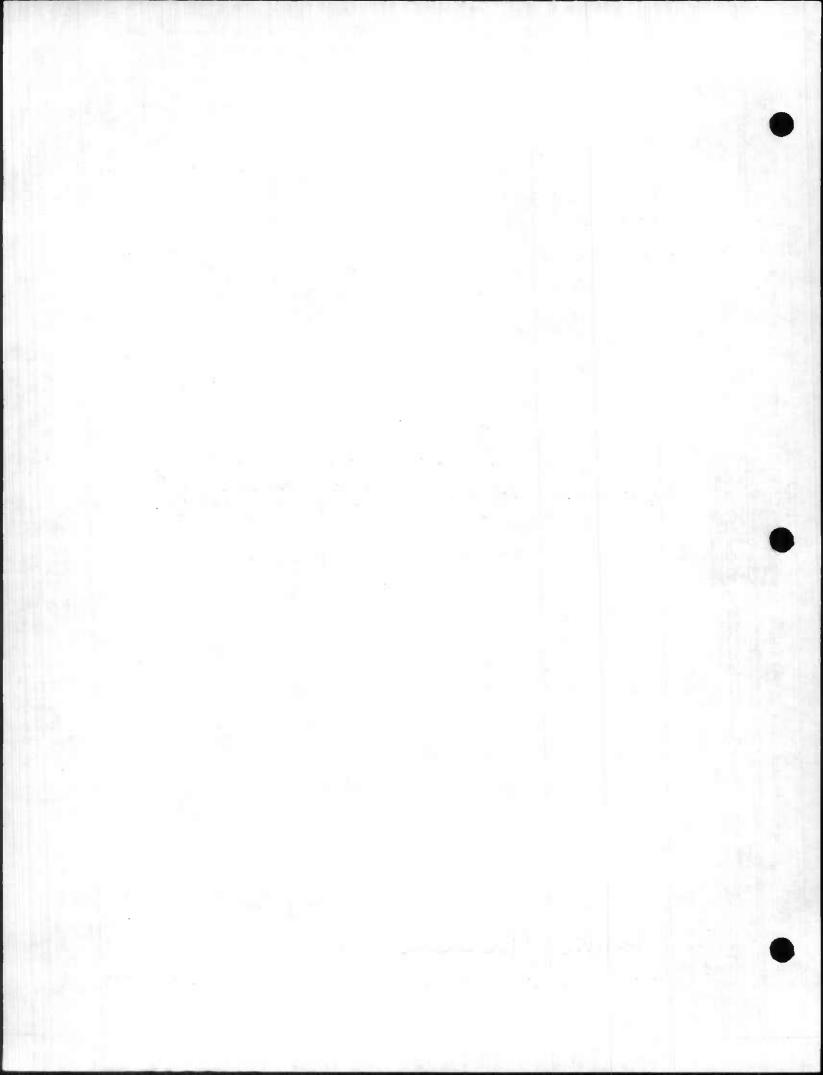
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner statad. 29a. Certifier edical (Check only one) 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce D15333 9/8/99 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Thomas G. Johnson 311 N. fourth St., Oakland, MD 21550 31. Date filed (Month, Day, Year)
MAR - 8 1999 32. Registrar's Signature

State Registrar



State of Maryland / Department of Health and Mental Hygiene

				Certifical	e or	Dealli		Reg. No.				
Physician	1. Decedent's Neme (First, Middle, La	est)					2. Dete of De Month	Day	3. Tima ot De			
/Medical	Ellen	A. Ibsen					March	9, 1999	3:00 A			
Examiner	4a Facility Name (If not institution, given	re street end number)				b. City, Town, or	Location of Deatl	4c. County of	Death			
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Funeral			(In yrs. last birth	day) If Unde	r 1 Year Days	If Under 24 Hrs Hours Min.	8. Date of Bir	th Veer!	9. Birthplece (State or F. Country)			
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8 w	10a. State 10b. County		10c. City, Town	or Location					10d. inside City t			
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rami by F	1 Never Merried 2 Married	1 ☐ Yes 2 ☒ N If Yes, Give		1 🗆 Yes	2 🛛 No	Specify:		Specify:	t.Th i to			
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B even	17. Father's Neme (First, Middle, Last	,				18. Mother's Na		Maiden Sumeme)				
To To	Peter Larsen					Alvil	da (Una	vailable	)			
D E E	19a. intormant's Name/Relationship (	Type, Print)	19b. I	Meiting Addres	s (Street	end Number or Ri	ural Route Numb	er, City or Town, S	tate, Zip Code)			
1 to 1	Amy I. Cordaro	(daught	er) S	Same as	10							
116	20a. Method of Disposition		20b. Place of D	Disposition (Ne	me of	na)	Date	20c. Location - C	ity or Town, State			
A B III	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			eake Cr		,	3-10-99	Poltanil	le, Marylan			
man.	21. Signature of Funeral Service Lice		Chesap			ss of Facility	5 10 55	Dellavii	ie, marylai			
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	( len )	1. Rap	P					pring, M	D 20910			
	23a. Part1. Enter the disease, or com shock, or heart tailure. List only	plications that caused	the death. Do no	at enter the mo	de of dyin	ig, such as cardie	or respiretory e	rrest,	Approximate tntervat Between			
ysician									Onset and Dea			
Medical	Immediate Cause (Final disease or condition	Cerebro	vascular	r Accid	ent				5 Years			
aminer	resulting in death)	θ	1000					) lears				
<b>6</b>			Due to (or es e co .tory Ari		•				1			
n and ist-transit Examiner		b	_									
al-tra	Sequentially list conditions, if any, leading to immediate		Due to (or es a co	insequence ot)								
buri al	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hijury that initiated events	c										
physician and as the bunal-transit edical Examir	resulting in death) Lest	D	Due to (or as a co	nsequence of):								
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he attending and for use a sician/M	Part II. Other eignificant conditions of	ontributing to death bu	t not resulting in t	the underlying	cause giv	en in Part t.	23b. Did	tobacco uee contr	ribute to the cause of c			
by the atter stached for u	Part II. Other eignificant conditions of	contributing to death bu	t not resulting in t	the underlying	cause giv	en in Part t.			ribute to the cause of c			
aned by the attending detached for use detached for use by Physician/N	Part II. Other eignificant conditions of	contributing to death bu	t not resulting in t	the underlying	cause giv	en in Part t.						
gned by the be detached by Physics	Part II. Other eignificant conditions of	contributing to death bu	t not resulting in t	the underlying	cause giv	en in Part t.	1 🗆	Yea 201No :	3 Probably 4 Un			
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has been signed by the ge 2 should be detached mpleted by Physi	Part II. Other eignificant conditions of	contributing to death bu	t not resulting in t	the underlying	cause giv	en in Part t.	1 ☐ 24e. Wes	Yea 201No :	3 Probably 4 Un  24b. Were autopsy find available prior to completion of caus of death?			
has been signed by the ge 2 should be detached mpleted by Physi		contributing to death bu	t not resulting in t	the underlying	cause giv		1 ☐ 24e. Wes perfo	en autopsy med?	3 Probably 4 Un  24b. Were autopsy tind available prior to completion of cau:			
ector, page 2 should be detached ector, page 2 should be detached Be Completed by Physi	25. Was case referred to medical axaminer?		t not resulting in t	the underlying		26. Place of De	24e. Wes perfect	en autopsy med?  Yes ZEI No one)	24b. Were autopsy find available prior to completion of caus of death?  1 Yes 2 No.			
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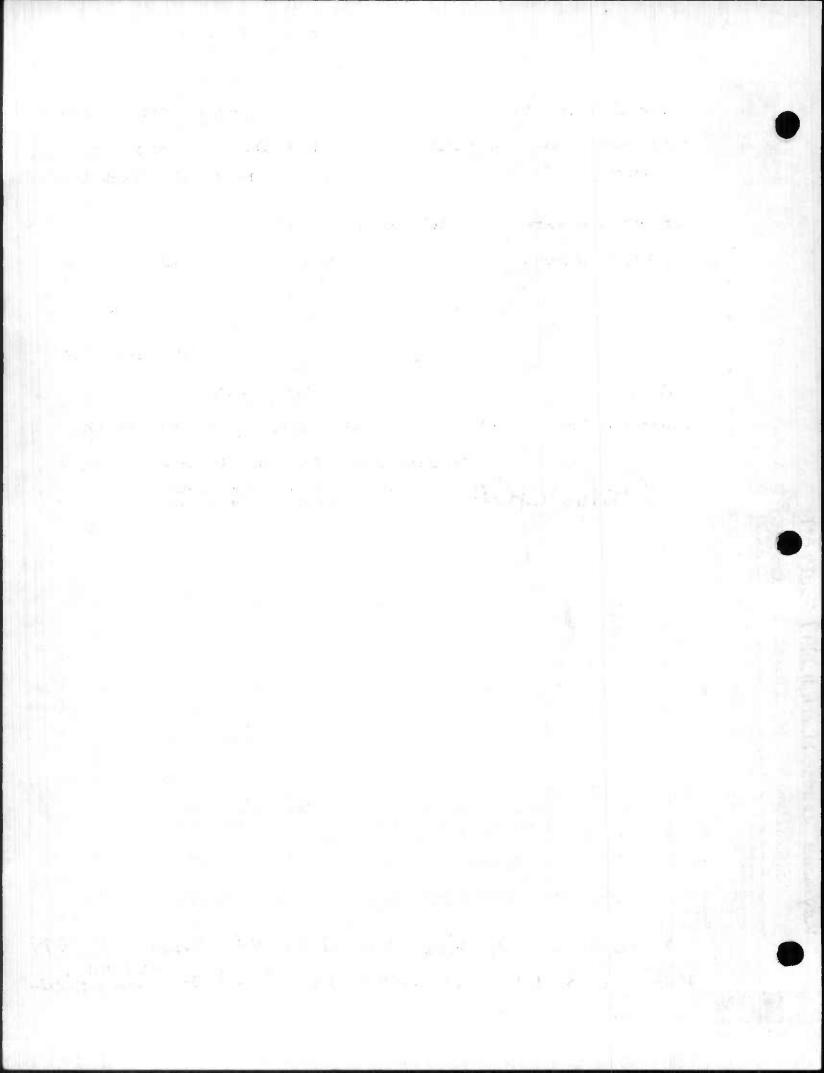


State of Maryland / Department of Health and Mental Hygiene 9 9 9 9 7

					Cei	rtificate of	Death		Reg. No.	0	2121
		1. Decedent's Name (First, Middle, La	ist)					2. Data of De	ath		3. Tima of Death
Physici /Modi		Raymond Fletche	er Jones					Month	Day	Year	2-15 136
/Medie Examir		4a. Facility Name (If not Institution, gire		er)			4b. City, Town, o	March or Location of Deat			3:45 AM
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Evenuel		Collingswood Nurs 5. Social Sacurity Number 6.5	Sing & Re	nabili Age (in vrs.	LEATIOT last birthday)	If Under 1 Yea	Rockvi r   If Under 24 H	I le	Mont	gomer	cy lace (State or Forei try)
Funeral Director			1⊠M 2□F		Yrs.	Months Days		in. (Month, De			
		Usual Residence of Decedent		87				Feb.15	1912	North	n Carolin
land w		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limit
Maryland -f show	5	W 1 1 W									1 ☐ Yes 2√€ N
tha Maryland 28a-f show	ect	Maryland Montgon  10e. Street and Number	nery	Si	llver S						
with the	Director	Toe. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	try?
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ar dae	Funeral	11. Marital Status	12. Was Decede Armad Force	nt Evar in U, s?	,S. 13. \	Was Decadent of f Yes, specify Cu	Hispanic Origin? ban, Mexican, Pur	(Specify Yas or No arto Rican, etc.)	- 14. Rad	ce - Amarica	
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in i	d by	3 Widowed 4 Divorced	Year or Date	s: WW I	I	- 100 - X	opoony.		Specii	Whi	te
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e filed other	Be (	17. Fathar's Name (First, Middla, Last	)				18. Mother's N	lama (First, Middla	Maiden Suman	na)	
Ked butter	To	Gabriel Jones					T 41	E1			
2 should be and Mantal Is marked of reumatic eve	-	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	n Addrass (Stree		Fletcher Rural Route Numb		State 7in	Code)
C/ 00 00 00											
s 1 and 3 Health item 27 other tr	1	Kathleen H. Jones 20a. Mathod of Disposition	(W)	ife)	IUIU3	Gardine Sition (Name of	er Avenu	e Silver	Spring 20c. Location	MD_2	.0902
agas int of t: If its		1 ⊠ Burial 2 □ Cremation 3 □			emetery, crem	natory or other pl	ace)	Date	200. Location	· City of To	WII, Stata
Pa Emar Emar Emar Emut:		4 □ Donation 5 □ Othar (Specif		Parl	klawn 1	Memorial	Park	3/14/99	Rockvil	le Ma	rvland
Daltimore, pemit. Pagas 1 at Department of Haa Important: If item; eny Injury or othe		21. Signature of Funeral Service Licer	1see	0		. Name and Addi	ass of Facility				
n sarra		1 ( IMMAN)	1(Ha	Vo	Fr	ancis J.	. Collins	s Funeral	Home,	Inc.	
		23a. Part1. Enlar the disease, or com shock, or haart failure. List only	plications that caus	sed the death	n. Do not ente	Univer or the mode of dy	ing, such as cardi	Vd., W., Si	lver Sp	ring,	MD 2090:
Physician		snock, or haart failure. List only	one dausa on aach	n line.						1	Interval Between Onset and Death
/Medical		Immadiate Causa (Final	D		\						
Examiner		disaase or condition resulting in daath)	. Phei	imo	nia	/					
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and and I-tra	xar	Sequentially list conditions, if any, leading to immediate		Due to (or	r as a conseq	uenca of):					
g physicien as the burial		Sequentially list conditions, if any, laading to immediate cause. Enter Undarlying Cause (Disease or Injury	C								
entificate be executed ding physicien and sa as the bunal-transit	edicai	that initiated events resulting in death) Last		Due to (or	as a consequ	uenca of):				1	
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tha daath y the ettar	Sici	Part II. Other aignificant conditions of	ontributing to death	but not resu	ulting in the un	darlving cause g	ivan in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death
iras that the death cersigned by the ettandind be detached for use	Physician	11 - 12 - 12 - 12 - 12 - 12 - 12 - 12 -				,			Yes 2 No	3 ☐ Prob	
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he law requiras that has been signed b aga 2 should be date								24a Was	an autopsy	24b. We	re autopsy findings
v requir been si should	Completed								rmed?	ava	illable prior to
e law has b	G L										death?
Fad	3							101	res 2 No	1□	Yes 2 No
ysician: The		25. Was casa referred to medical axaminer?					26. Place of D	eath (Chack only o	ne)		
2 00	2	1 Yas 2 No	Hospital: 1 ☐ Inpa	itiant 2 🗆 I	ER/Outpatient	3□ DOA O	her: 4 Nursing	Home 5 ☐ Resid	denca 6 □Oth	er (Specify	·)
		27. Mannar of Death	28a. Date of In	jury	28b. Time of	28c. Inju	ıry at		now Injury occur		
a fur	읉	1 Natural 5 Pending investigation	(Month, E	Jay ( Gar)	Injury		ork? ]Yes 2∐No				
or Attending I after death. Director: After I in by the funer	Certification:	3 ☐ Sulcide 6 ☐ Could not be	286. Place of I	njury - At ho	me, farm, stre	et, factory, office		28f. Location (S	Street and Numb	per or Rural	Route Number,
Dir	ert	4 Homicide	building,	etc. (Specify	)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tov	vn, State)		
pltal surs srai		20a Cartillar Manageria	11			- Partition II					
To the Hospital or Attendition and the Hours after death.  To the Euneral Director: Accomplately filled in by tha fu	edical	Check only Z Medical Exam	ysician: To the bes niner: On the basis	of examinati	vieoge, daath ion and/or Inv	occurred at the ti estigation, in my	ma, date and plac opinion, daath occ	ce, and due to the curred at the time,	causa(s) and ma date and place.	and due to	ated. the causa(s)
the the	-	Grief)	and manner	stated.							
5 ¥ € 000	-	29b. Signatura and title of cartifier	·	1	2	29c, Licen			29d. Date signa		
OU		Kathari	ne of	X	elie 1	115	1532	44	mare	260 1	1, 1990
DI		30. Name and address of person who	completed causa of	death (Item	23a) (Type, F	Print)			D	sek !	ille
		Katharine R.	Lillie		1114	O Rom	KVIIIO I	44.   :	48	MAD	2005
Stat		31. Date filed (Month, Day, Year)		trar's Signat	ura /	1	1.	1100	, ,	V 1 1	20007
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Jones March 11, 1999 63: 45 AM

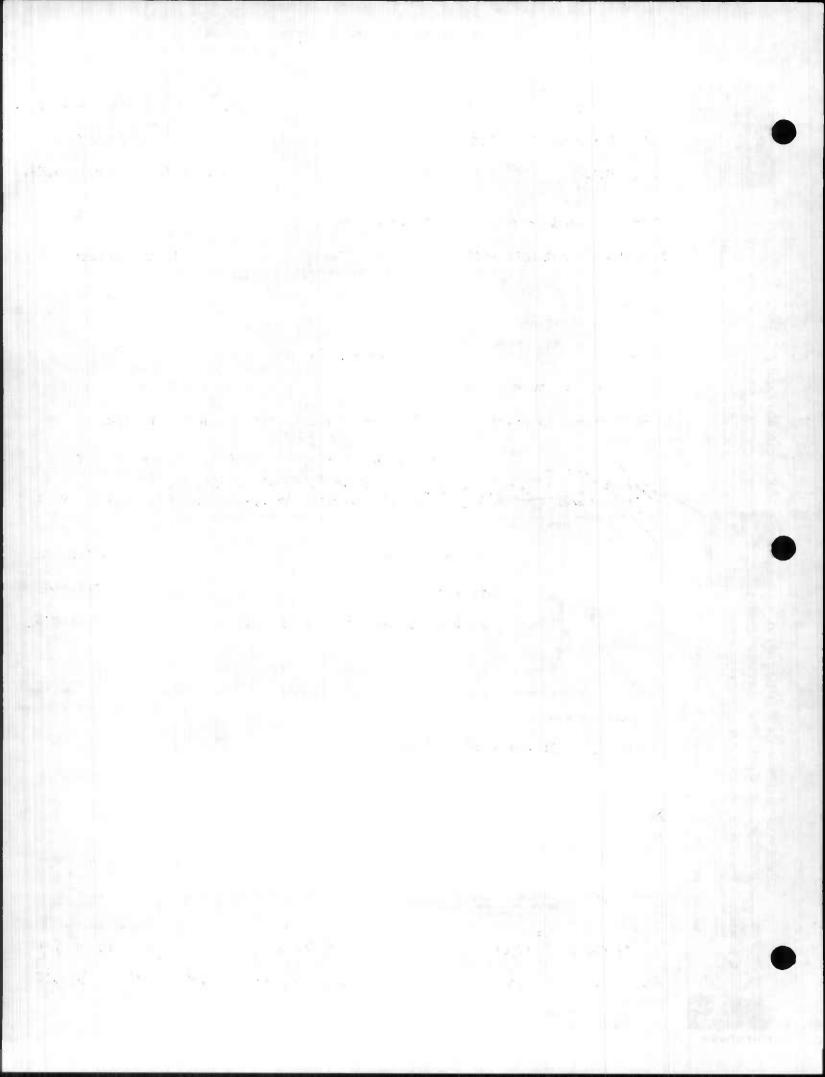
Raymond



State of Maryland / Department of Health and Mental Hygiene Q

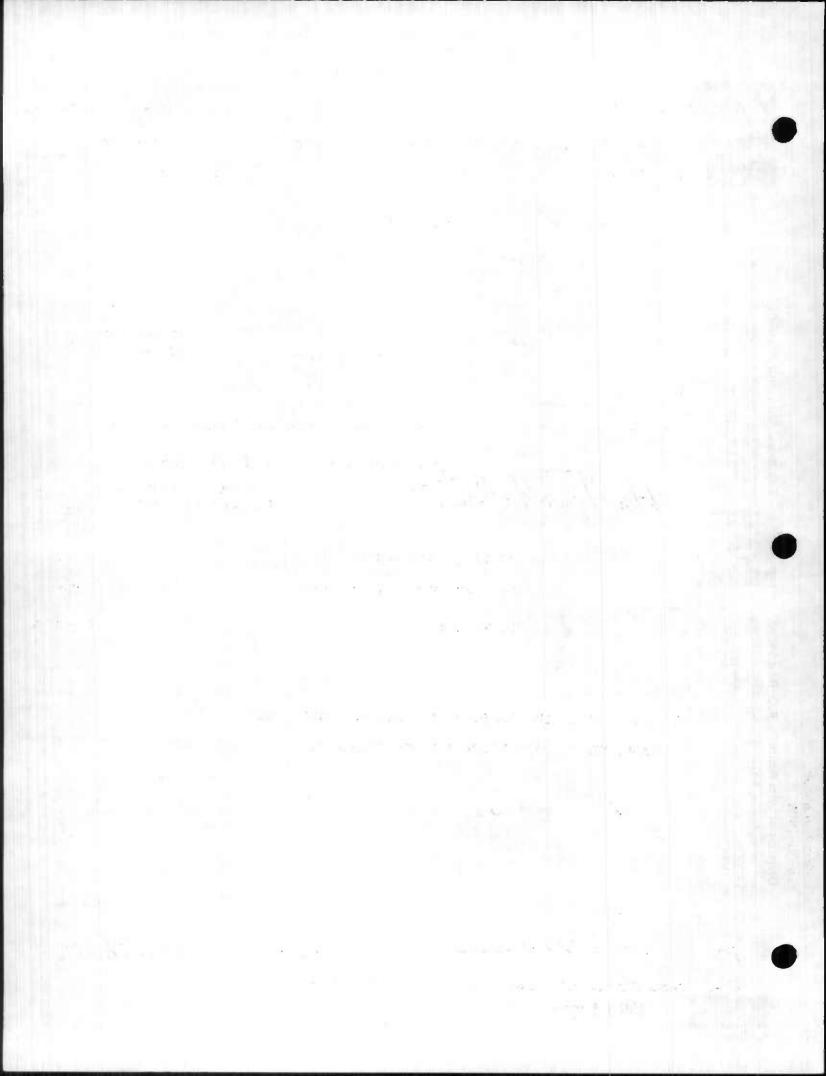
Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Deeth Month 8 Day **Physician** 4:26 P.M. JONES March /Medical 4a Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY 8. Data of Birth (Month, Day, Year) Oct. 6, 1939 If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2\ F Deys Hours 59 Yrs. 425 86 8662 Waynesboro, MS. Director Usuai Rasidanca of Dacedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylend Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or items 23s or 28s-f ahow any fourty or other traumatic event, it a Medical Examinar man be notified at another. 10a. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yas 2 □ No Director Maryland Montgomery Silver Spring 10e. Street end Number 10g. Citizan of What Country? 10f. Zip Code 1505 November Circle #402 20904 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yas, Giva Year or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Ricen, atc.) 14. Rece - Amarlcen Indian, Black, Whita, atc. 1 Nevar Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) Collega (1-4or 5+) Dietary Manager Hospital 18. Mothar's Nama (First, Middla, Meidan Sumema) 17. Fathar's Nama (First, Middle, Last) Taylor Jones Ida Lee Smith 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Straat and Number or Rural Routa Number, City or Town, Steta, Zip Code) Helen Graham (Sister) 11 Boenau Street, Albany, New York 12202 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Graceland Cemetery 3/16/99 Albany, New York 4 Donation 5 ☐ Othar (Specify) 22. Name and Addrass of Facility
McGuire Funeral Service Inc. Fungral Service Licenses 7400 Georgia Ave., N.W., Washington, D.C. 20012 Inter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrast, or heart failure. List only one cause on each line. Approximeta Intarvel Batween Onsat end Deeth Physician /Medical mediate Cause (Final cardiac arrist 25min disease uc.ceridition resulting in death) Dua to (or as a consequance of): Examiner 30 min Seizuse Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting.) Dua to (or as a consequence of): physician a s the burial-2 months accident Division of Vital Records, P.O. Box 68760 cubrovascular Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by d be detact 1 Yes 2 No 3 Probably 4 Unknown Hyputinsion by 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy Diabetes Mellitus complation of cause of daath? **page 2** 2 No 1 Yas 1 ☐ Yas 2 ☐ No certificate Be 25. Was cesa rafarrad to medical 26. Piece of Deeth (Check only ona) 1 Yes 2 No Hospitai: Other: 4 ☐ Nursing Homa 5 ☐ Residance 6 ☐ Other (Specify) Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA #6 27. Mannar of Daath 28e. Date of injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? Affer Attending 1 Natural 5 Panding 1 Yas 2 No invastigation 2 Accident 6 Could not be datamined 3 Suicida Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) A Par 4 - Homicide Funeral D Hospital tixCertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and dua to the ceusa(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to tha ceuse(s) and menner stated. Medical 29a. Cartifian 24 To the P within 2 To the P complet 29b. Signatura end titla of certifier 29c. Licanse number 29d. Data signad (Month, Day, Year) Eller M / 11 how MD 51015 30. Name end eddress of person who complated ceusa of daath (Itam 23a) (Type, Print) Chen Chise mD 20815, Ellen Pinholt 5530 Wisconsin Ave Suite 1045 31. Data filad (Month, Day, Yeer) 32. Registrar's Signatura State MAR 1 1 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

Provided Part Medical Control (Part Medical					0.0.00	ivial y lai	C	ertifica	te of	Death		Reg. N	99	0.9	199	)
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James Raver, M.D., Memorial Hospital, Cumberland, MD 21502		10		40//	11/2	~			7	D 18769		Mar	ch 3	17	, 1999	)
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State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LEONARD WILLIAM JACKSON MARCH 1999 9:57PM /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 5651 SPRINGDALE ROAD EAST NEW MARKET DORCHESTER H Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) NOV 23, 1925 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 220-26-1478 73 Yrs Director MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND DORCHESTER EAST NEW MARKET Director 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 5651 SPRINGDALE ROAD 21631 USA Funeral 12. Wes Decedent Ever in U,S.
Ammed Forces?
1 ☑ Yes 2 ☐ No 1944—
If Yes, Give
Year or Dates: 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 1 Never Manled 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3 Widowed 4 Divorcad Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygien
Important: If them 27 is marked other tha
any injury or other traumatic even-REGULATOR REPAIR OXYGEN TANK 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) CARL JACKSON ALVINIA DISKAU 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) HELEN M. JACKSON/WIFE 5651 SPRINGDALE ROAD, EAST NEW MARKET, MD 21631 20b. Placa of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation → Other (Specify) EAST NEW MARKET CEMETERY 3/6/99 EAST NEW MARKET, MD 21. Signatury of Funeral Service by 22. Name and Address of Fecility ZELLER FUNERAL HOME, P. O. BOX 207, en 106 MAIN STREET, EAST NEW MARKET, MD 21631 plication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. An Port L. Enter the disease, or complication that is, or heart failure. List only one cause Approximate Interval Between Onset and Death /Medicai immediate Cause (Final disease or condition resulting in deeth) Cardiae 3 minutes Due to (or es e consequence of): Examiner Cholangiocarcino Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting In death) Last Due to (or es a consequenca of) Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown à 24a. Was an autopsy performed? 24b. Were autopsy findings evalleble prior to completion of cause of death? Completed Diabetec 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homleide 154 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. Medical 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DS0804 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Cambridge, Maryland, 21613 Mallars

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32. Registrer's Signature

Geneva

State Registrar 31. Date filed (Month, Day, Year)

MAR 0 9 1999

28a-f show

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natural, or

filed within 7. Hygiene.

**Physician** 

Examiner

physician end the buriel-transit

To the Mospital or Attending Physician: The lew requires that the death certificate be executed within £4 hours effect death.

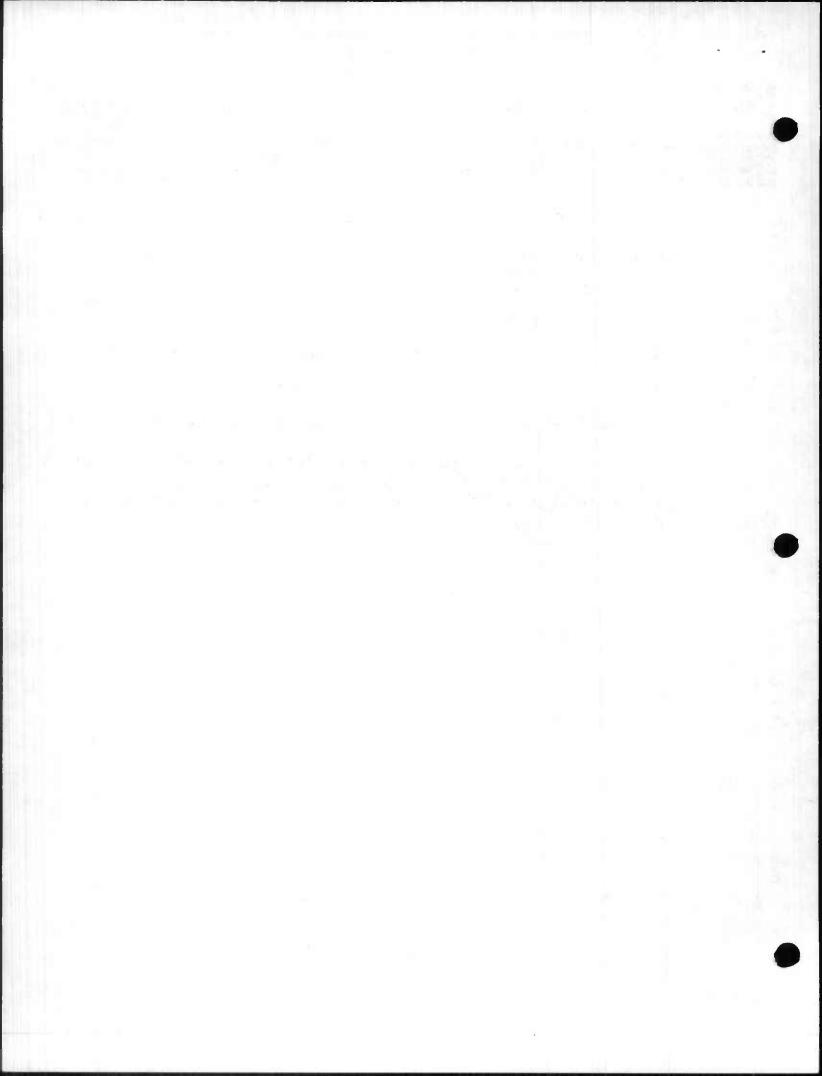
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P.O. Box 68760,

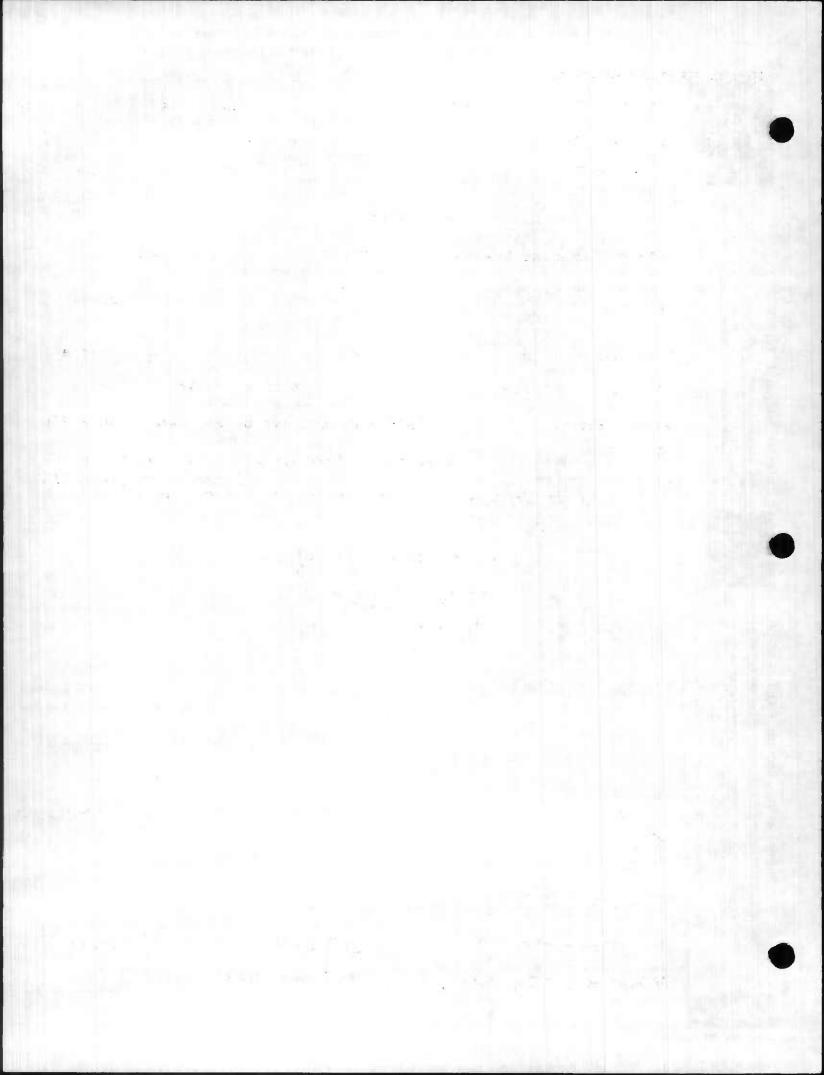
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Baltimore, Maryland 21215-0020



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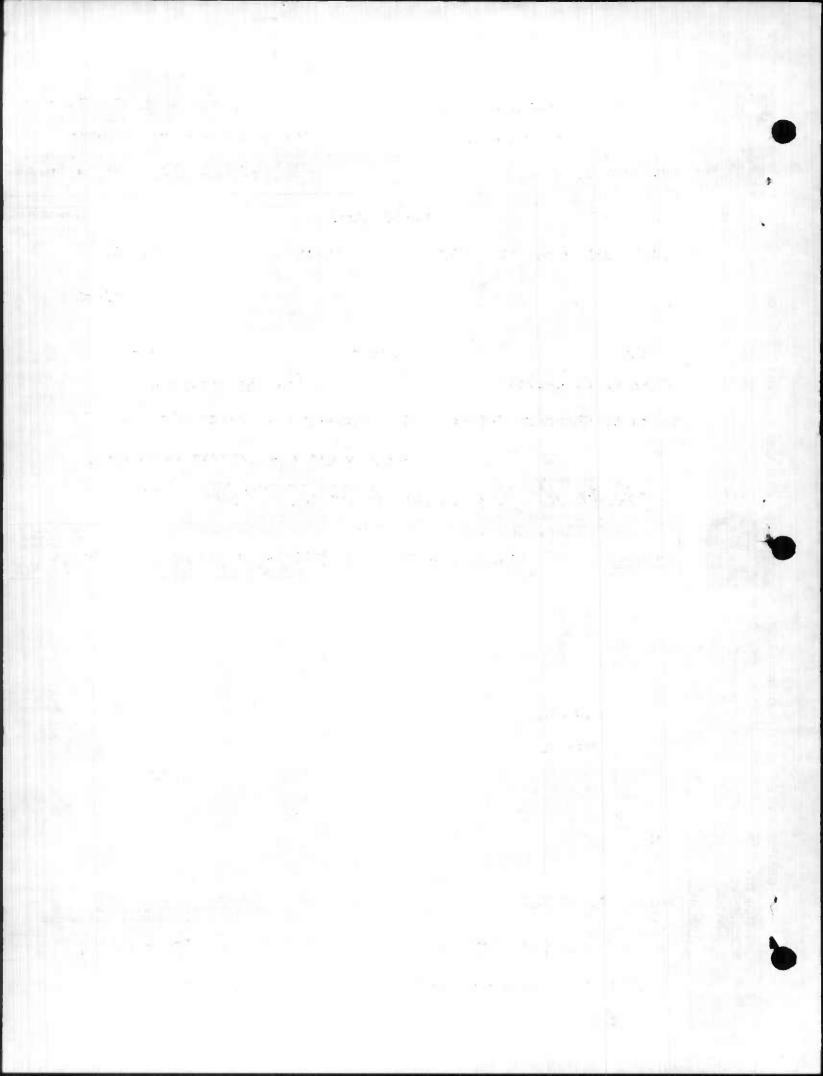
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dey 5, **Physician** MARCH CARROLL **JOHNSON** 7:22 PM MARY /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medlantic of Layhill Silver Spring MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Pay, Year) Feb. 10, 1926 9. Birthplace (Stete or Foreign **Funeral** Days 1□ M 2MF Months Hours Maryland 73 577-44-7032 Director Usual Residence of Decedent 10c. City, Town or Location 10e Stele 10h County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinar must be notified at tr Yes 2 No Director Washington, DC death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20010 U.S.A. 1451 Park Road, NW, #312 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by ₩idowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filled wit Department of Health end Mantal Hygienn Important: if them 27 is marked other than any injury or other traumatic event, the once. Domestic Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Charles C. Carroll Vashti Williams 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6300 Kennedy St., Riverdale, MD 20737 Laura L. Chambers (Niece) 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Slete Arlington Nat'l Cem 3/17/99 Arlington, VA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name end Address of Facility SNOWDEN FUNERAL HOME, ROCKVILLE, MD 20850 ROCKVILLE, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or hearly failure. List only one ceuse on each line. **Physician** /Medical Immediate Cause (Final . Chronic obstructive pulmonary disease disease or condition resulting in death) Examiner Examiner buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last pue Due to (or as a consequenca of) Records, P.O. Box 68760, physician Physician/Medicai the Due to (or es a consequence of) 88 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown 1 | Yee 2 | No cachexia signed b by cate has been signated by page 2 should b 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? aremia certificate has 1□ Yes 2 No 1 TYes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: ASSING Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA After this 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Natural To the Hospital or Attendir thin 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and menner stated. edical 29a. Certifier 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) Ellen m tinhout mo D 51015 15-99 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Ave Suite #1045 Chery Chase 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State MAR 1 9 1999 Registrar

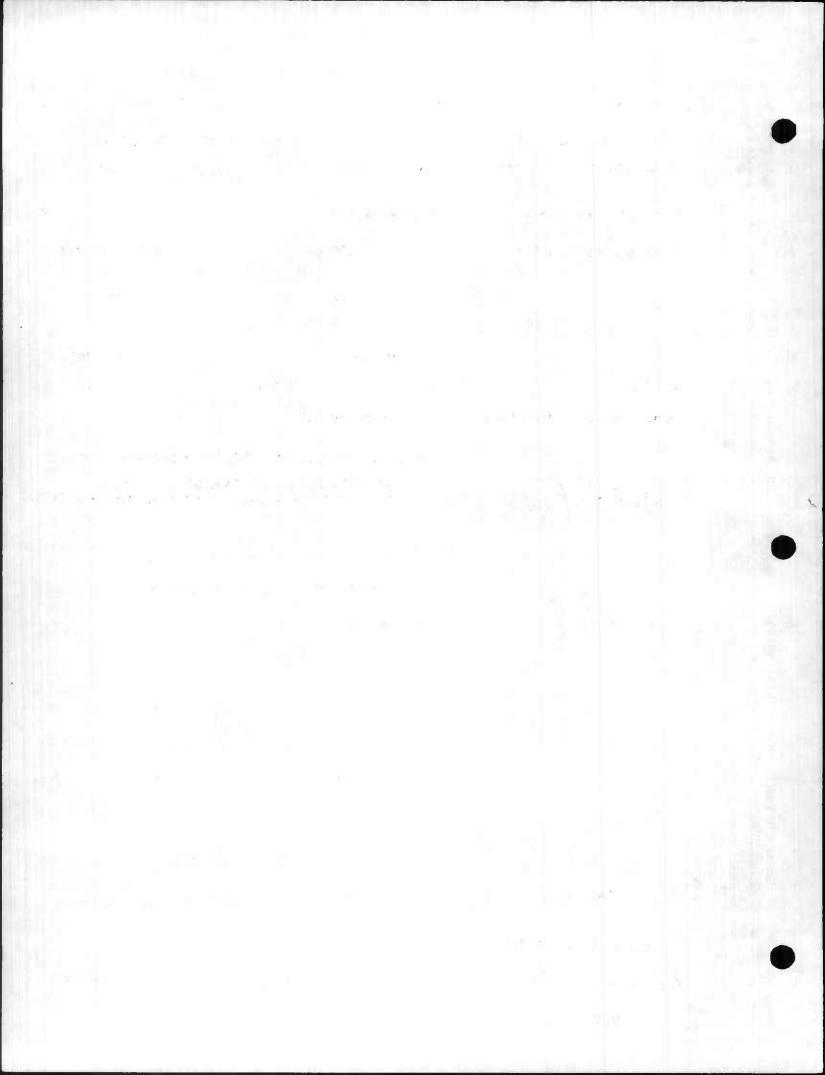
**DHMH 16 Rev 6/95** 

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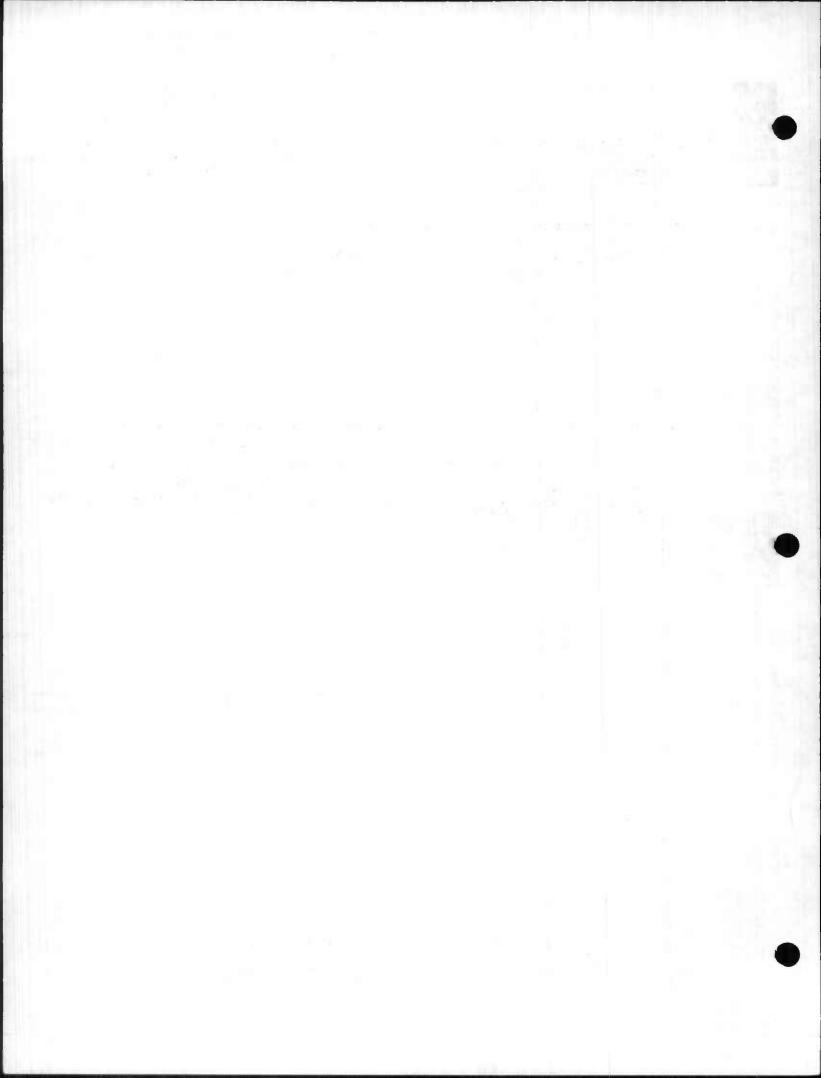


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3 Time of Deeth Dey 1999 ar **Physician** March 7, Shirin Kara 8:30P. /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Nov. 8, 1918 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Deys Hours 1 M 2XX 220-17-7159 80 Yrs. India Director Usuel Residence of Decedent with the Marylend permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Marylen Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny Injury or other treumatic svent, the Wed call Exporter treum to notified an page. 10b. County 10c. City, Town or Location 10d. fnside City Limits Maryland Montgomery Burtonsville 1 Yes XXNo Director 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? 3223 Hollyhock Drive 20866 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 ☐ Yes ZZZNo If Yes, Give Yeer or Dates: 1 □ Never Merried 2 □ Merried 1 Yes 2X No Specify: Specify: Asian P **¾** Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Aladin Pate1 Manji 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Noor Lakhani (daughter) same as #10 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition XX Burial 2 Cremetion 3 Removel from Stete MD National Memorial Park 3/8/1999 Laurel, Maryland Donetion 5 Other (Specify) Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one-cause on each line. Approximete intervel Between Onset and Death **Physician** Ischemic Cardiomyopathy
Due to (or es e consequence ot):
Congestive heart failure /Medical immediate Cause (Final disease or condition resulting in death) 4 ear Examiner Physician/Medical Examiner physician end s the bunal-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Diasctes Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by should l 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to Completed completion of cause of deeth? s certificate has b 281 No 1 ☐ Yes 2 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: 1 □ Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? After 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident within 24 hours efter deeth To the Funeral Director: , completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner es steted.
2 Medical Examinar: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end manner stated. 29e. Certifier edicai (Check only one) To the Vithin 2 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number Ceral Sternlar D43496 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Montammon A Khalid Mb 8630 Fenton Street Suit 700 Silve Pring up 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar MAR 1 1

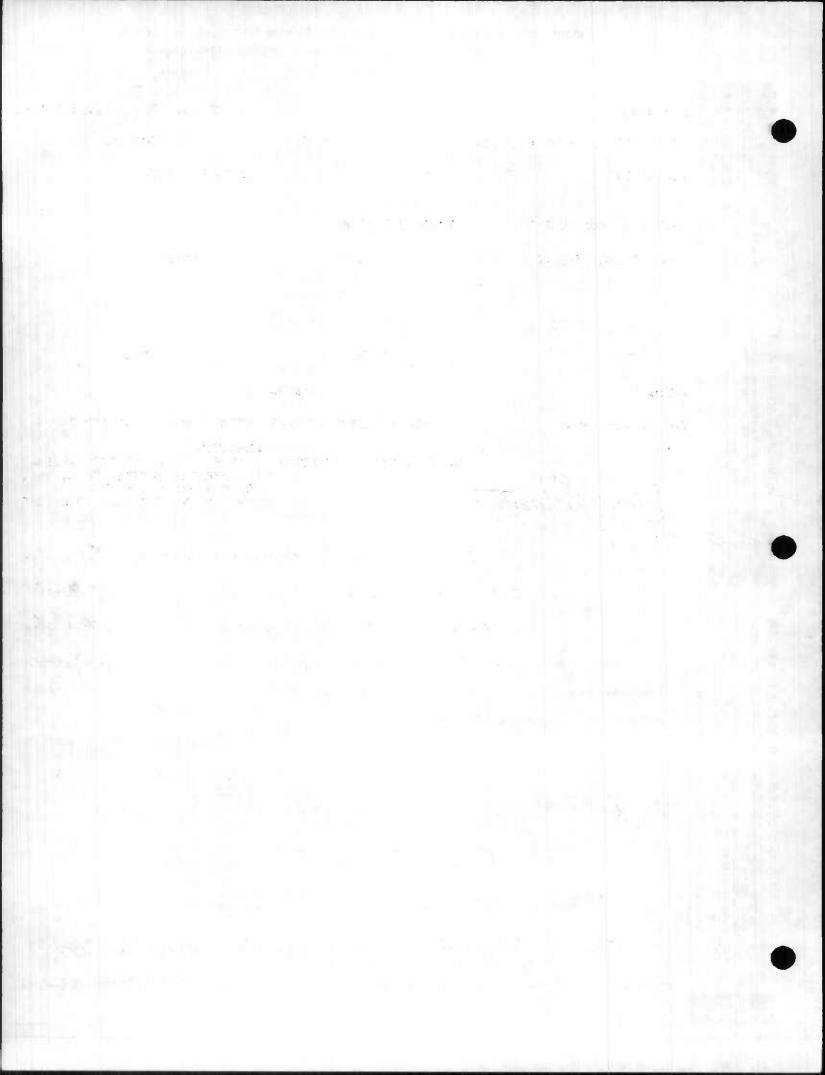


			State of Maryla		riment of the			Reg. No.	000	04
Physic /Med		Decedent's Neme (First, Middle, Last)     BOK	KIM	1/***			2. Dete of De Month	Dey 9	Yeer	ne of Deeth
Exam Funera Director		3/0 /4 4233	ventist Hos	spital :. lest birthday) Yrs.	If Under 1 Yeer Months Deys	4b. City, Town, or ROCKV  If Under 24 Hrs Hours Min	ille  8. Date of Bir	MOI	9. Birthplace (St Country) Korea	
aryland show d at		Usuel Residence of Decedent  10e. State 10b. County	10c. C	ity, Town or Loc	ation					de City Limits
vith the Ma	Director	Maryland Montgome	ery G	Germanto	10f. Zip Code			10g. Citizen of V	Whet Country?	Yes 2 No
be filed within 72 hours effer death with the Maryland tall Hygiene.  Identify than "natural", or items 23a or 28a-f show event, the Medical Exercises invested to the province invested in the Medical Exercises.	by Funeral	18350 Timko Lane  11. Marital Status  1□ Never Merried 2□ Married  3♥ Widowed 4□ Divorced	12. Wes Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:		20874 es Decedent of I Yes, specify Cub ☐ Yes 21 No	Hispenic Origin? ( an, Mexicen, Puer Specify:	Specify Yes or No to Rican, etc.)	United  14. Rec Blee  Specify	e - American Indie ck, White, etc.	n,
	Completed	15. Decedent's Edu (Specify only highest grade Elementery/Secondary (0-12) 1 2	cation	(Give ki	ont's Usuel Occup ind of work done O NOT use retire emaker	during most of wo	orking		usiness/Industry Home	
Mary ylallia Z. I.Z. d.2 should be filed within th end Mental Hygiene. 7 Is merked other than traumatic event, tre.	To Be C	17. Fether's Neme (First, Middle, Last) Hyong Sam Kim				Sun	me <i>(First, Midd</i> le, Kyong	Maiden Surnan Chang	ne)	
end 2 : lealth er m 27 is her trau		19e. Informent's Neme/Relationship (Ty Chan Ko, Son  20e. Method of Disposition 1□Burlel, 2 GCremetion 3□R	20b.		ighland	Oaks Dr.		ia, CA		:e
permit. Pages 1 er Depertment of Hea Important: If Itam; any Injury or other		4 Donafibn 5 Other (Specify)  21. Signetylre of Funerel Service Livense	/ Me		Name end Addre		1999 DeVol	Funeral		20877
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death certificate be executed e ettending physician and of for use as the buriel-trensit	Medical Examiner	Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest	Due to (d	or es e conseque						
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The law requires that the ate has been signed by the page 2 should be deteched	Completed by						24e. Wes	en eutopsy rmed?	24b. Were eutopeveileble prompletion of deeth?	rior to
certifica rector,	To Be Col	25. Wes cese referred to medical exeminer?  1 Yes 2 No	lospitel:	] ER/Outpetient	3□ DOA Ott	nor:	eth (Check only of	ne)	1 ☐ Yes	2□ No
r Attending frer deeth. Frector: Affer n by the fune	ertification:	27. Menner of Death 1 \$\infty\$ Naturel 2 \infty\$ Accident 3 \infty\$ Sulcide 4 \infty\$ Homicide	28e. Dete of Injury (Month, Day Year)  28e. Place of Injury - At h building, etc. (Special	28b. Time of Injury		ry et rk? IYes 2 ☐ No		now injury occur Street and Numb vn, State)	red er or Rural Route	Number,
To the Hospital or within 24 hours after To the Funeral Director completely filled in	edical Ce	29e. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my knorer: On the besis of examine end menner steted.	owledge, deeth o	occurred et the til stigetion, in my o	me, dete end place	e, end due to the	ceuse(s) end me date end place,	enner es steted. and due to the ceu	se(s)
To the Complex	Me	29b. Signeture end title of certifier  Chiba Lympul			29c. Licens	se number  WD 42	452	29d. Dete signed	d (Month, Day, Yea	er)
		30. Name end eddress of person who con ig III, prince PHIL.				CHITTEA A				
St Regist	ate rar	31. Dete filed (Month, Day, Year)  MAD 1 1 190	32. Registrer's Sign		lon	1.1				



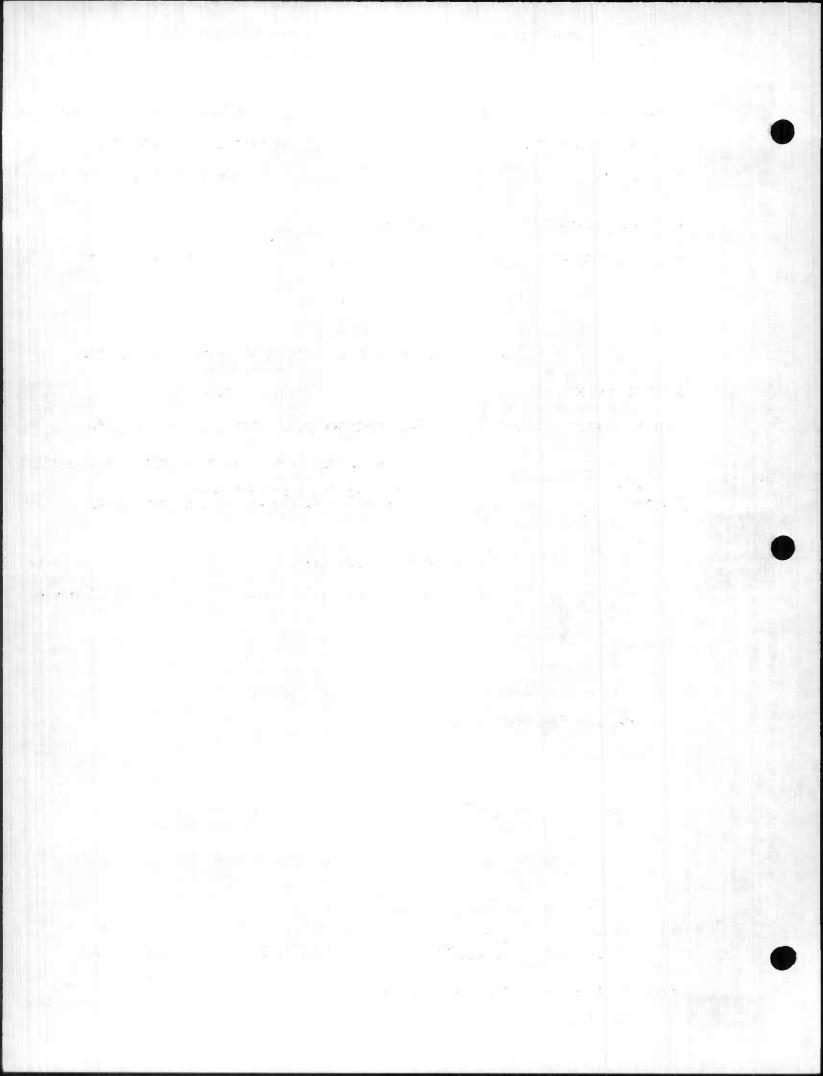
## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener

	1. Decedent's Name	e (First, Middle	le. Last)					2. Dete of	Death		3. Time of Death
cian	1. Decedent 5 Num	o (r iros, isnoo	, Lasty					Month	Dey	Yeer	
lical	HEE DONG						4. Oh. Taua	or Location of De			10:00 P.M
iner	4a Facility Neme (//							or Location of De		nty of Death	
	MONTGOMER					v) If Under 1 Y	OLNEY	Hee I a D		COMERY	
	5. Social Security N		6. Sex 1 ☐ M 2X		yrs. last birthde			Vin. (Month,	Dey, Yeer)		place (Stete or Foreign untry)
	214-88-52 Usual Residence of				90 Yrs.			AUG.	05, 1908	KORI	EA
	10e. Stete	10b. County	,	10	c. City, Town or	Location					10d. inside City Limits
5											1 ☐ Yes XX No
2	MARYLAND	MONTG	OMERY	S	SILVER S		W1		10g. Citizen o	4 Mart Co	Partners.
Director	10e. Street and Nur	nber				10f. Zip Co	OB .		rog. Cilizen o	WHAT COL	antry?
בחומום	14421 TAR	PON TE				20905			KOREA		dana da dina
	11. Marital Status		Armo	Decedent Ever ed Forces?	r In U,S. 13	If Yes, specify	of Hispanic Origin Cuban, Mexicen, P	(Specify Yes of uerto Ricen, etc.)	No- 14. H	iack, White	rican Indien, o, etc.
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	UNKNOWN						UNKNOW				
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	ROY W. KI	-	)					1			AND 20905
	20a. Method of Disp		3 Removal	from State	20b. Place of Dis cemetery, cr	position (Neme or other	r place)	MAR. 08	20c. Location	n - City or 1	Town, State
	4 Donation				SATE OF	HEAVEN (	CEMETERY	1999	-	SPRIN	NG MARYLANI
	21. Signature of Fu	neral Service	Ligensee			22. Name and A					HOME, INC.
	Man	201	shows	7				1800 NEW			
	23a Part Fnter ti	he disease, or	complications	they daused the	deeth. Do not e	enter the mode o	f dying, such es cer	TLVER SE	KING MAI y arrest,	KYLANI	D 20904-289 Approximete
	shock, or hea	rt failure. List	only one cause	e on each line.							Interval Between
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ı	Immediate Cause ( disease or condition resulting in deeth)		a/	Acute	e str	oke		ain s	,		Onset and Death
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State of Maryland / Department of Health and Mental Hygien® 0

	1 Decedant's Nom	e (First, Middle, Last	1)		Cen	ificate	OIL	Jealn	2. Dete of De	Reg. No.		3. Time of Death	
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· /Medical		NE BARBARA					A	b. City, Town, or I	1 0 10 10 10 10 10 10 10 10 10 10 10 10	9, 199	nty of Deeth	5:00 A.1	1.
Examiner	Miles School of College			,									
	5. Social Security N	OSS HOSPIT		ne (In vrs	lest birthday)	If Under 1		SILVER S. If Under 24 Hrs.			GOMER		
uneral Pirector	579-28-72 Usuel Residence of	219	DM 201 F	74	. Yrs	Months	Days	Hours Min.	8. Date of Birl (Month, De MARCH			place (Stete or Foreign ntry) NNSYLVANIA	
item 27 is marked other than "natural," or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	10e. Stete	10b. County		10c. Ci	ty, Town or Loc	ation					1	10d. Inside City Limits	
to to	MARYLAND	MONTGOME	ERY	STI	LVER SPI	RING						1 ☐ Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	
Director	10e. Street end Nur	mber				10f. Zip C	Code			10g. Citizen	of Whet Coul	ntry?	
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by Fu	1 Never Marri	ied 2/Q/Merried	1 X Yes 2 If Yes, Give	No		Yes 2			o nican, etc.)	Spe	Bleck, White, cify: WI	eic. HITE	
8		15. Decedent's Edu	ucetion		16a. Decede	ent's Usuel	Occupa	ation		16b. Kind o	f Business/In		
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Be	17. Fether's Name	(First, Middle, Last)						18. Mother's Nar	ne (First, Middle,	Meiden Surr	neme)		
ToE	ANTHONY N	MOLESKI						EMILY Z	IEMNICKI				
	19a. Informant's Na	ame/Relationship (T)	ype, Print)		19b. Mailing	Address (	(Street e	and Number or Ru			wn, Stete, Zip	Code)	
	PETE P. K	KLAPPS - S	SPOUSE		9718 1	BRADD	оск	ROAD, S	LLVER SP	RING.	MD 200	903	
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Physician/N	B								1				
ysie	Part II. Other signif	Icant conditions co	ntributing to death	but not res	sulting In the un-	derlying car	use give	en In Part I.			/	o the causa of death?	
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npie											of	death?	
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To B	27. Menner of Deeth	h 5 ☐ Pending	28a. Date of Inj (Month, D	ury ey Year)	28b. Time of fnjury	28	c. Injury Work	et c?	28d. Describe	how Injury oc	curred		
	27. Menner of Deeth 1 Waturel	investigation		,,	,,	М		Yes 2 □ No					
2	1 ☑ Naturel 2 ☐ Accident		28e Piece of Ir		ome, farm, stre	et, factory,	office		28f. Location (. City or Tox	Street and Nu	imber or Run	al Route Number,	
2	1 Maturel	6 Could not be determined	building, e	1-1-511									
0	1 ☑Naturel 2 ☐ Accident 3 ☐ Sulcide	6 Could not be											
	1 Anaturel 2 Accident 3 Sulcide 4 Homicide	6 Could not be determined	building, e	of examina	owledge, deeth	occurred et estigation, i	t the tim	e, dete end place pinlon, death occu	, end due to the irred at the time,	cause(s) and dete and plac	manner es s ce, and due t	stated. o the cause(s)	
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pletely filled in by the funeral direction: To	1 Active 2 Accident 3 Sulcide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and	6 Could not be determined  1 Certifying Phy 2 Medical Exami	sician: To the best ner: On the basis end menner s	of examinated.	ntion and/or inve	estigation, i	License	oinlon, death occu	rred at the time,	dete and place 29d. Date sig	gned (Month,	Dey, Year)	



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** March 9, Mildred Kloeppinger 1999 6:25AM /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not Institution, give street and number) 4c. County of Death Examiner Manor Care Chevy Chase Montgomery If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 577-60-1935 1□ M 25kF 103 Yrs. 4, 1895 Washington, DC **Director** Usual Residence of Decedent Baltimore, Maryland 21215-0020

Spermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiena.
Important: If Hem 27 is marked other than "naturel", or Hems 23s or 28s-1 show any injury or other traumetic event, the Waddel Exemples matter profiled at page. 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MXYes 2 No N/A N/A WASHINGTON, D.C. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2022 Columbia Road #511 20009 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 15 Never Married 2 Married White 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) U.S. Government Claims Examiner I.R.S. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mathilda Streitberger William Kloeppinger 19e. Informent's Neme/Relationship (Type, Print) Attorney 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Wilkes Artis Hendrick & Lane 1666 K Street, N.W., Washington, D.C. 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 □ Cremation 3 □ Removal from State 3/18/99 Washington, D.C. Prospect Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Joseph Gawler's Sons INC., 5130 Wisconsin Ave. NW, Washington, DC 20016 23a. Part1. Enter shock, or heart film ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) one week Stroke Examiner Due to (or as a consequence of): Examiner physician end the buriel-transit thet the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical thet initiated events resulting in death) Lest Due to (or as e consequence of): 88 use Ö signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes Z No 3 Probably 4 ☐ Unknown ð 24b. Were autopsy findings avellable prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 has 2 No 1 Yes 1 Yes 2 No certificate or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending Investigation 1 Natural eftar death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours e Hospital ix Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end placa, and due to the ceuse(s) and manner as stated.

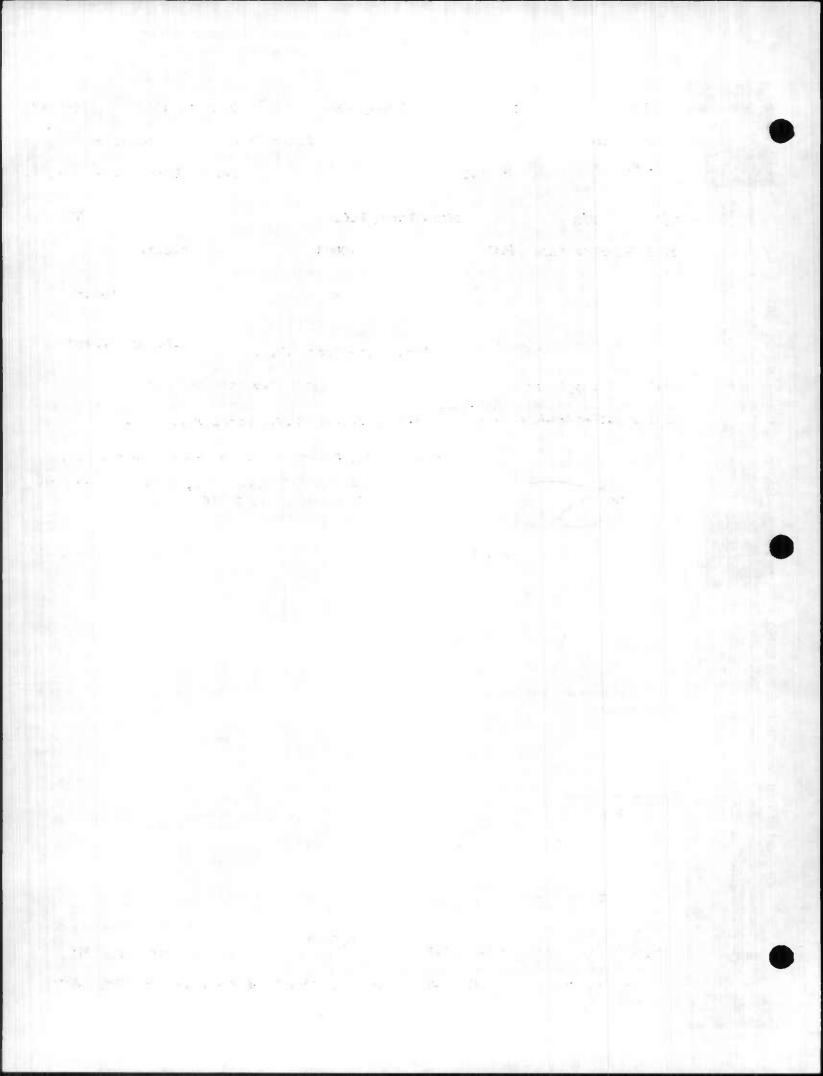
2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier Medicai completaly (Check only one) within 2 To the 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) D29353 due March 9, 1999 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George W. Graves MD., 5530 Wisconsin Ave. NW #925 Chevy Chase, MD 20815-4330 31. Date filed (Month, Day, Year) 32, Registrar's Signature

Registrar

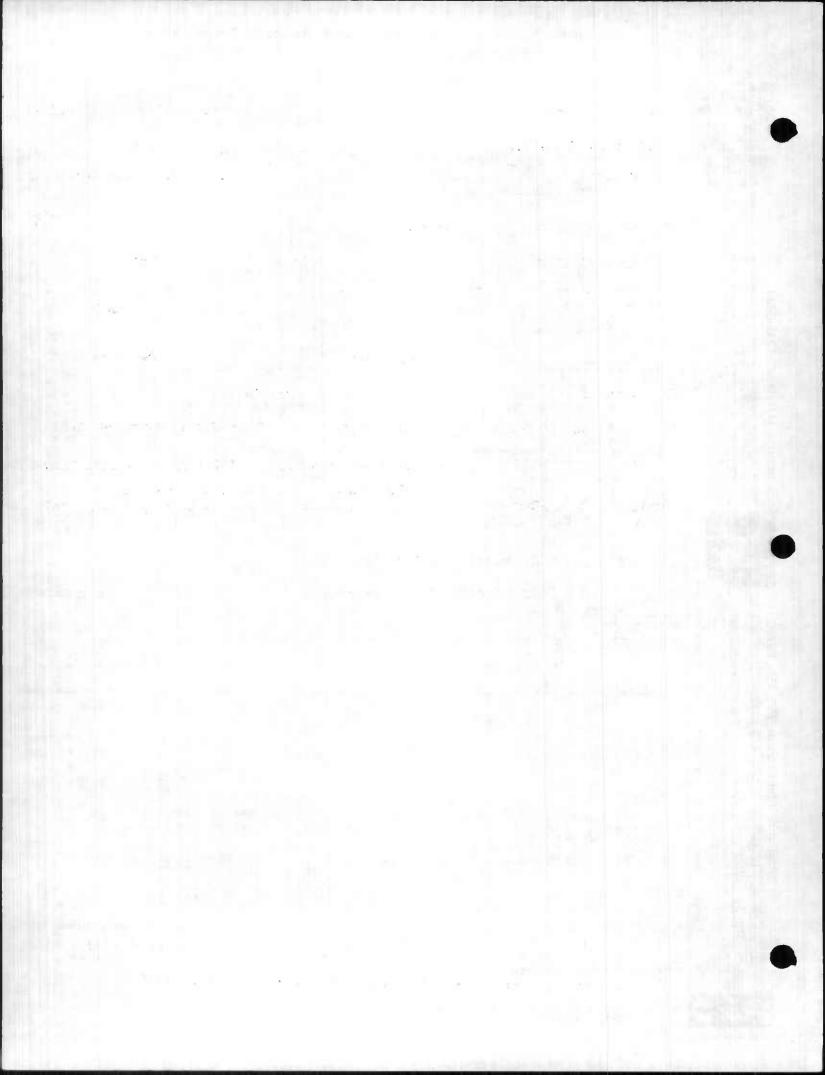
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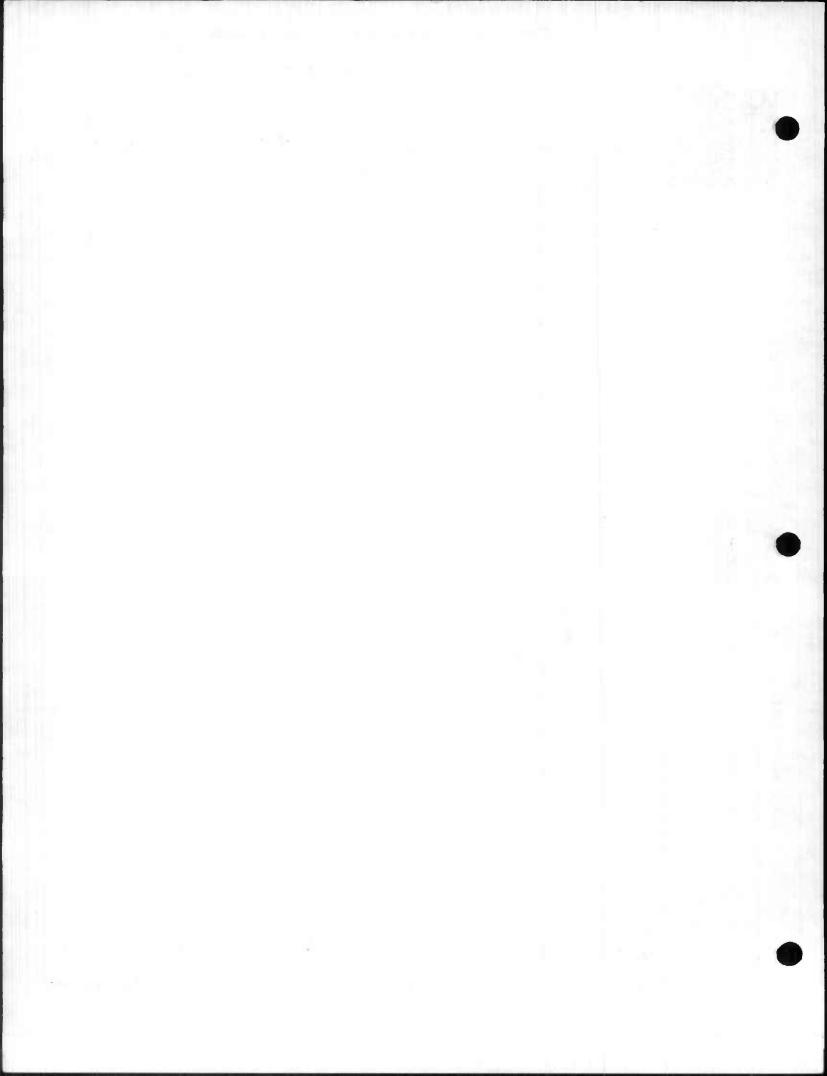


			(	ertificate	of Death		Reg. No.		
	1. Decedant's Nama (First, Middla, L	ast)				2. Data of	Death	Maria	3. Time of Death
Physician	Mary E. Kr	ebs				Month	Day 9. 1999	Yaar	12:17 AM
/Medical	4e Facility Name (If not institution, g				4b. City, To	wn, or Location of De		y of Death	12:17 AM
Examiner									
	Holy Cross Hos  5. Sociel Security Number 6.	Sax 7. Age (In	yrs. last birtho	(av) If Undar 1 Y	Silver	Spring 24 Hrs. 8. Data of	Birth Mont	gomery	Co (State or Foreign
Funeral		IDM ONE	Yr	Months   D	ays Hours	Min. (Month,	Birth Day, Yaar)		ace (Stete or Foreign ry)
Director	577-10-5771 Usual Rasidance of Decedent	88				Oct.1	9,1910	Washi	ington, DC
and w	10a. Stata 10b. County	100	City, Town	or Location				10	d. Insida City Limits
Aary or									1 ☐ Yas 2 ➡ No
hours after death with the Manyland ural, or flems 23s or 28s-f show al Evantiner must be notified at ed by Funeral Director	Maryland   Montgon	ery C	nevy C	10f. Zip Co	de		10g. Citizen of	M/hot County	n/2
s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiens.  If Health and Mental Hygiens "natural", or frems 23a or 28a-f ahow other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director.	100. 3(180) 610 (101106)			101. 210 00	- Via		rog. Onzon or	vviior count	
r froms 23s where must	8415 Spencer Cou				20815		USA		a ta dia
E S	11. Marital Status	12. Was Decedant Ever Armed Forcas?	In U,S.	tt Yes, specify	t of Hispenic Ori Cuban, Maxicar	gin? (Specify Yes or n, Puarto Rican, atc.)	No- 14. Had Bla	ce - America ck, Whita, a	
V F	1 Naver Merried 2 Merried	1 ☐ Yes 2 ☑ No If Yas, Giva		1□ Yas 2	No Specify:		Specif	y:	
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rt, the wedcal	15. Decedent's I (Specify only highast g		(0	ecedent's Usual O Biva kind of work o	lona during mos	t of working	16b. Kind of B	lusinass/Indu	ustry
de le	Etementary/Secondary (0-12)	Cotlega (1-4or 5+)	11	fa. DO NOT usa r	etired)				
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Be ve	17. Fethar's Nama (First, Middla, Las	it)			18. Mothe	ar's Nama (First, Mid	dla, Meidan Sumar	ma)	
o Life	Martin Mulroe				Mar	y Quill			
m n	19a. tntormant's Name/Raiationship	(Type, Print)	19b. A	Mailing Addrass (S		er or Rural Route Nu	mber, City or Town	, Stata, Zip (	Coda)
r tra	Karl W. Krebs	(husband)	841	Spencer	Court	Chevy Ch	ase, Mary	brelv	20815
other to	20a. Mathod of Disposition	20	b. Placa of D	isposition (Name crametory or othe	of	Data	20c. Location	- City or Tov	
y or	1 ☑ Buriel 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Othar (Spec					1011010			
right.	21. Signatura of Funarai Sarvica Lice	(1)	sate o	22. Nama and A	Cemeter	y 3/13/9	9 Silver	Sprin	g,Marylan
Important: If it any injury or once.	. 1			Promode	T C-114	- Thuman	1 Home.	Inc.	
	Johns SV	Josex		500 Unive	ersity F	Blvd. W. S	ilver Sp	ring.M	D 20901 Approximata
	23a. Pent 1, Enter the disease, or co shock, or heart tailure. List onl	mplicetions that aused that y ona causa on each line.	daath. Do no	anter tha moda o	f dying, such as	cardiac or raspirator	y arrest,		Approximata Intarvat Between
sician								1	Onset and Death
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EX EX	Sequantiatly list conditions, if any, leading to immediate cause. Enter Underlying							i	
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for to									
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page 2 should						24a. W	las an autopsy erformed?	ava	ra autopsy tindings litabla prior to
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o T						1	□Yas 2ÅNo	10	Yas 2□ No
director, page 2 s	25. Was casa ratarred to medical		-		26 Pleas	e of Death (Check or			
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oral dire	27. Manner of Death		,		4DN		be how injury occu		/
fune lon	1 ⊠Natural 5 ☐ Panding	28a. Data of tnjury (Month, Day Yaa	ir) Inju	ary M	tnjury at Work? 1 Yas 2		,,		
the car	2 Accidant Invastigati 3 Suicide 6 Could not	be one Diseased Injury	At home for				n (Street and Num	her or Pural	I Route Number
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₩ com	29b. Signature and title of certifiar		n	29c. L	icensa number		29d. Dete sign	ed (Month, L	Day, Year)
		12000	NI	) 0	50678		MAL	9 199	9
	30. Name and address of person who	complated causa of death	(itam 23a) (T	/pe, Print)	010		1		•
	Rnjeer Bata	A MU 1141	1/41	A word D	R Silver	Speing N	10901 41		
State	31. Date tiled (Month, Day, Year)	32. Registrar's S	ignatura			- 0 - 1.			
State Registrar		99 Senew	e /	1. Ann	Kel				
	11(PIL) - () 10	/-	10	· KARACAL	and a				



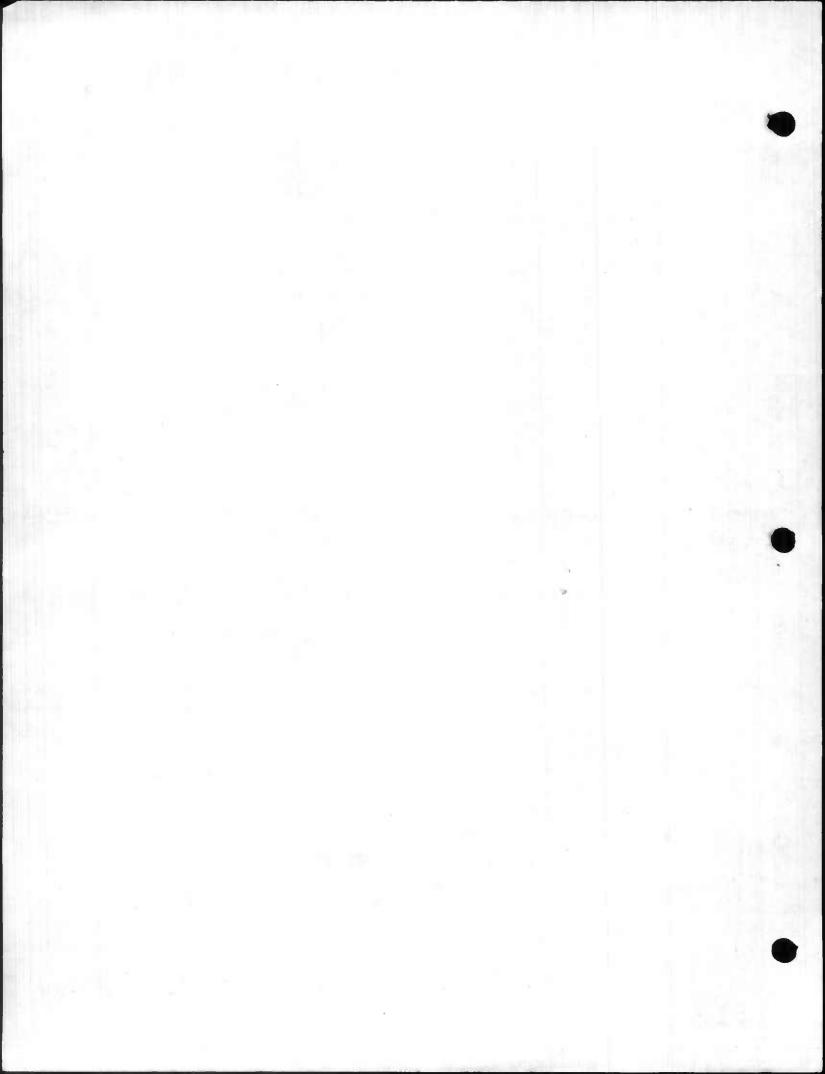
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		Decedent's Name (First, Middle,	I ast)	-		ate of	Dealli	2. Date of De	Reg. No.	2	Tim f th
hysician			Last)					Month	Day	Yeer	
/Medical		LOUIS KRIEG  4a. Facility Name (If not institution,	aive etreet and number	4			4b. City, Town, or	MAR.	8, 1999 h 4c. County		06:51
Examiner							ockvil				
uneral	7	Shady Grove A	6. Sex. 7. A	HOSDIT ge (In yrs. last birth	day) If Und	der 1 Year	If Under 24 Hrs	8. Date of Bir		gomery	Stete or Foreig
rector -		090-12-4101	1₽M 2□F		rs. Month	ns Days	Hours Min	OCT. 5	, 1923	Country)	(Stete or Foreig NY
	- 1-	Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town	or Longtion					404 le	alda Cita I imis
Po Po		, , , , , , , , , , , , , , , , , , , ,									Side City Limits
notified at	3	MD MONTGO	MERY	GAITHE		Zip Code			10g. Citizen of V	What Country?	•
r tems 23a or 28a-f s rner must be notified Funeral Director	2	220 KENTLANDS B	TUD #202		10	20878	0	1	US		
Jers Jers	<u>.</u>	11. Marital Status	12. Was Deceden	Ever in U,S.	13. Was De		dispanic Origin? (\$ en, Mexican, Puer	Specify Yes or No		e - Americen In	dlan,
"natural", or items 23s or 28s-f sho edical Examiner must be notified at leted by Funeral Director		1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorcad	Armed Forces d 1 Yes 2 If Yes, Give Year or Dates:	No		pecity Cubi	en, Mexican, Puer Specify:	to Rican, etc.)	Specify	ck, White, etc. :: WHIT	าน
ted ted	3	15. Decedent's	Education	16e. l	Decedent's U	sual Occup	pation	. dela a	16b. Kind of Bu		
To Be Completed	2	(Specify only highest Elementary/Secondery (0-12)	College (1-4or		life. DO NOT	use retire	during most of wo d)	nking	SINGER		
rt, the Medical	5	12			MACHI	NIST			KNITTING		JES
Be Be	ם מ	17. Father's Name (First, Middle, La	BSt)				18. Mother's Na	me (First, Middle	, Maiden Sumem	16)	
other traumatic event,		MORRIS KRIEG	- C		A de la companya de l	(0)		A GERSHM			
		19e. Informent's Name/Relationshi			_		and Number or R				
other t	1	SHIRLEY KRIEG / 20a. Method of Disposition	WIFE	20b. Plece of I			BLVD.,	F203, GA	20c. Location -		
y or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spe									
in in		21_Signature of Funeral-Service bi		KING D			IAL GARD,	3/10/9	9 FALLS	CHURCH	I, VA
any injury or once.		115	DANIEL S		DANZA 1170	NSKY- ROCKV	-GOLDBERG	G MEMORI KE, ROCK	AL CHAPE VILLE, M	ELS. INC	3.
		23a. Pert1. Enter the disease, or co shock, or hear failure. List or	omplications that cause nly one cause on each	d the death. Do no line.	t enter the m	ode of dyir	ng, such es cardia	c or respiratory e	errest,	Inter	oximate val Between
cian Iical		Immediate Cause (Finai								Offis	et and Deeth
iner		disease or condition resulting in death)	e CARDIO	GENIC SHO						MIN	JUTES
e e			CODOMA	Due to (or as e co		,				3777	NDC.
s the bunel-transit		Sequentially list conditions	b. CORONAL	Due to (or as a co	1					YEA	CAL
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	ACUTE F	RENAL FAI		1				ONE	E DAY
edicai		Cause (Diseese or injury that initiated events resulting in death) Last	С.	Due to (or as e co		if):				01	
6		and and	d								
for use e			<b>-</b> U.								
deteched for use	F	Part II. Other significant conditions	s contributing to death	out not resulting in	he underlyin	g cause giv	ven in Part I.	23b. Dld	tobacco use cor	ntribute to the	cause of death
								10	Yes 2 No	3 Probably	Unknow
2								24a Was	an eutopsy	24b. Were ei	Itopsy findings
page 2 should	-								ormed?	available	prior to ion of ceuse
Com								10	Yes 2 No		2 □ No
Be C		25. Was case referred to medical					26. Plece of De	ath (Check only			
		examiner? 1 ☐ Yes ※XXNo	Hospital: 1 🖾 Inpati	ent 2 ER/Outp	atient 3	DOA Oth	Ar.		denca 6 □Othe	er (Specify)	
		27. Menner of Death	28e. Dete of Injui	ury 28b. Tin	ury	28c. Injur Wor		28d. Describe	how Injury occurr	red	
		1 ØNatural 5 ☐ Pending	tion		М		Yes 2□No				
a   -		2 ☐ Accident investigat	t be	to and	n ctroot fact	ory, office		28f. Location ( City or To	Street and Numb	er or Aural Rou	re Number,
by the funeral		2 ☐ Accident investigat	t be 28e. Place of in	jury - At home, farr tc. <i>(Specify)</i>	ii, sii <del>oo</del> i, iaci			0.0, 0	WTI, 31818)		
by the funeral dire	2	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)  2 Medical Ex	28e. Place of in building, e  Phyeician: To the best caminer: On the basis of	tc. (Specify) of my knowledge, of examination and/	deeth occurre	ed at the tir	me, date and plece	e, end due to the	cause(s) and me	enner es steted.	cause(s)
by the funeral	2	2 Accident 3 Sulcide 4 Homicide  29a. Certifier (Check only one)  1 CertifyIng 2 Medical Ex	28e. Place of in building, e	tc. (Specify) of my knowledge, of examination and/	deeth occurre or Investigati	on, in my o	pinion, death occi	e, end due to the	cause(s) and me date end place, a	and due to the o	
by the funeral	2	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28e. Place of in building, e Phyeician: To the best caminer: On the basis of end manner st	tc. (Specify) of my knowledge, of examination and/	deeth occurre or Investigation	on, In <i>m</i> y o 29c. Licens	epinion, death occi	e, end due to the	cause(s) and me date end place, a 29d. Dete signed	d (Month, Dey,	Year)
pletely filled in by the funeral diedical Certification: To	4	2 Accident 3 Sulcide 4 Homicide  29a. Certifier (Check only one)  1 CertifyIng 2 Medical Ex	28e. Place of in building, e  Phyelcian: To the best taminer: On the basis of end manner st	of my knowledge, of examination and/lated.	deeth occurre or Investigation	on, In <i>m</i> y o	epinion, death occi	e, end due to the urred at the time,	cause(s) and me date end place, a 29d. Dete signed	and due to the o	Year)



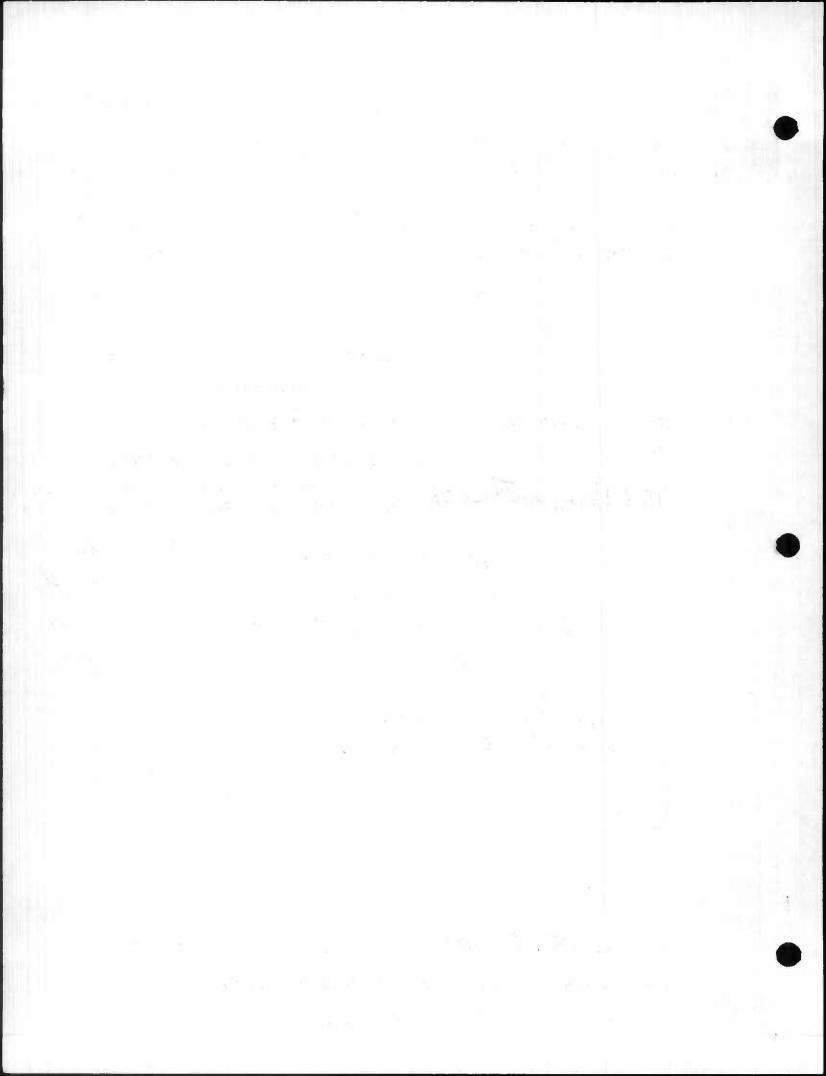
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

		Certificate of Death	Reg. No. 99 09210
Physician	1. Decedent's Neme (First, Middle, Last)	1)(/	2. Dete of Death  Month  Dev  Year  1056
/Medical Examiner	te Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death 4c. County of Death
	Washington Haventist	Hospital Taxomo	i Pavil Mont. Co.
Funeral Director	12-6:(5) 1173 404 604	yrs. last birthday)   ff Under 1 Year   ff Under 24 Hrs.   Months   Deys   Hours   Min.	8. Dete of Birth (Month, Dey, Year) 9. Birthplece (State or Foreign Country). Ukraine
Mand wo		. City, Town or Location	10d. Inside City Limits
Man and and ctor	Maryland Montgomery	Silver Spring	1 ☐ Yes 2 ☐ No
ifier death with the Ma rites rount be notified Funeral Director	10e. Street and Number 9014 Sudbury Rd	10f. Zip Code 20901	10g. Citizen of What Country? USA
by II.	11. Maritel Status  1 Never Married 2 Merried  3 Widowed 4 Divorced  12. Wes Decedent Ever in Armed Forces?  1 Yes, Sive Year or Detes:	in U.S.  13. Was Decedent of Hispanic Origin? (Spetif Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☑ No Specify:	ecity Yes or No- Rican, etc.)  14. Race - American Indian, Bleck, White, etc.  Specify: White
ed within 72 hours at ygiene. wr than 'natural', or it, the lipidial Earth Completed by F	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work)	16b. Kind of Business/Industry
within in them or	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	
ges 1 and 2 should be filed within to f Health and Mental Hygiene. It of Health and Mental Hygiene. If item 27 is marked other than or other traumatic avent, the Health of the Health of the Health of the Health of Health	12 17. Fether's Neme (First, Middle, Last)	Homemaker 18. Mother's Name	Own Home a (First, Middle, Meiden Surneme)
d 2 should be file th and Mental Hy 7 is marked other traumatic avant To Be (	Paul Senchuk	Odarka	Unobtainable)
2 should and Men la marke aumatic	19e. Informant's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rura	al Route Number, City or Town, State, Zip Code)
1 end 1 Health am 27	Mykola Kryworuk/Husband	9014 Sudbury Rd, Silv	
permit, Peges 1 and 2: Department of Health as Important: If item 27 is any injury or other trau	20e. Method of Disposition  1X Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify)	Mb. Place of Disposition (Neme of cemetery, crematory or other plece)  St. Andrews Ukrainian	Dete 20c. Location - City or Town, State  Mar 8 South Boundbrook, NJ
permit, Pege Department of Important: If any Injury or	21. Signeture of Funerel Service Licensee  Alan J. Donnell		es-Rinaldi Funeral Home e Ave, Silver Spring, MD 2090
lew requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriel-transit auriel to the standard of	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that britished septime.	DOLLMON Y ON BY OF ONE OF ONE A CONSEQUENCE OF):	t
res that the death certification of the death certification of the detached for use a by Physician/M.	Pert II. Other algnificant conditions contributing to death but not	resulting in the underlying cause given in Pert I.	23b. Did tobacco use contribute to the cause of death?  1 Yea 2 No 3 Probably 4 Unknown
sician: The lew requires the certificate has been signe irector, page 2 should be do Be Completed by			24a. Wes an autopsy performed?  24b. Were eutopsy findings available prior to completion of cause of death?
certificate har rector, page	OF Was soon referred to medical		1 Yes 2 No
Physician: this certific ral director.	25. Was case referred to medical examiner?  1  Yes 22 No Hospitel: 1 Inpatient	26. Place of Death	n (Check only one) me 5 ☐ Residence 6 ☐ Other (Specify)
Attending Physic death.  ector: After this by the funeral di	27. Manner of Death 12. Netural 5 Pending (Month, Day Year 2 Accident Investigation		28d. Describe how Injury occurred
tal or Attanding P rs efter death. al Director: After it led in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp.		28f. Location (Street and Number or Rural Route Number, City or Town, State)
Hospit 14 hour Funer tely fill	29a. Certifier (Check only one) (Check only one) (Check only one)	knowledge, death occurred at the time, date end place, inination and/or investigation, in my opinion, death occurr	and due to the cause(s) end menner as stated. ed at the time, date end place, and due to the cause(s)
To the vithin To the comple	29b. Signeture and little of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
ia	1 til button	45203	3-7-99
۲	30. Name and address of person who completed cause of death (i	ND 7600 CAY(OI)	tue Takoma Park, NID
State Registrar	31. Dete filed (Month, Dey, Year)  MAR 0 8 1999  32. Begistrer's Si	gnature G. Sports	



State of Maryland / Department of Health and Mental Hygiene 9 09211

		Certificate of De	eath		g. No.		
Physician		1. Decedent'a Name (First, Middle, Last)		2. Dete of Deeth Month	_	1 <sup>Y</sup> 8ª5 9	3. Time of Deeth
/Medical	-	Henrietta D. Keim	No. Taura 1	March			10:00p
Examiner	ľ			ocation of Death	4c. County		
	٩,	WILLIAM HILL MANOR - MARVEL HALL  5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U	EASTON Under 24 Hrs.			LBOT	(2)
Funeral Director			lours Min.	8. Dete of Birth (Month, Day, MAR . 8,	Year) 1908	9. Birthple Counti NEW Y	
ms 23a or 28a-f show crount be notified at neral Director		10e. Stete 10b. County 10c. City, Town or Location				10	d. Inside City Limits
or 28a-f short be notified at		MD TALBOT EASTON					1 Yes 2 No
or 2		10e. Street and Number 10f. Zip Code		10	g. Citizen of W	/hat Count	ry?
23a		510 DUTCHMAN'S LANE 2160	01		USA		
ar, or its Examine by Fui		11. Maritel Stetus  1 □ Never Married  2 □ Married  3 □ Wildowed 4 □ Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Sive Yeer or Dates:  13. Was Decedent of Hispan If Yes, specify Cuben, Me 1 □ Yes 2 ☒ No Sp	nlc Orlgin? (Spe dexican, Puerto pecify:	ecify Yes or No- Ricen, etc.)		- America k, White, e	tc.
ygiene.  ner than "natural",  nt, the Medical Ex-		15. Decedent's Education 18a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during	n most of work	1	6b. Kind of Bu	siness/Indu	ustry
- # S	.  -	(Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)	ig most of work	ng			
Hygiene. ther than ent, tre M		12 2 HOMEMAKER			OWN H	OME	
I D L		17. Fether's Neme (First, Middle, Last)	Mother's Neme	(First, Middle, M	laiden Sumame	9)	
Mentel arkad o etic eve		JOHN MULLER M	MARIA DO	DROTHEA N	MOHRMAN	IN	
h end Mer 7 is marke traumatic TO		19e. Informent's Name/Reletionship (Type, Print)  19b. Mailing Address (Street and N	Number or Rura	al Route Number,	City or Town,	State, Zip (	Code)
12 E		PATRICIA E. MILLER/ DAUGHTER 26403 HERONWOOD	ROAD, H	EASTON, N	MD 2160	1	
~ = 0	12	20e. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)		Dete 2	Oc. Location - 0	City or Tow	m, State
Department of Important: If any injury or any injury or ance.		1 XBuriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify)  PINELAWN MEMORIAL PA	ARK 3	3-10-99 1	FARMING	DALE.	NY
d by the ettending physician and leteched for use as the burial-transit and property of the burial-transit and physician/Medical Examiner		23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sure shock, or heart feiture. List only one ceuse on each line.  Immediate Cause (Finel disease or condition resulting in death)  But 10 months and 10 months are consequence of the course. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest  Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in	bema	Tas 4	st,	7	Approximate Intervel Between Onset and Deeth Acy 5  unthy  Lay  Lay
by the teched	.   '	Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in	Pert I.				the cause of death?
be dete be dete by Pl		arpirofin syndrome		1 🗆 Yes	s 2 No	3 ☐ Probe	ibly 4 Unknow
2 should		chronic april fibilation	•	24e. Wes en perform		com	e eutopsy findings leble prior to pletion of cause eath?
page page				1 □ Yes	2 No	10	Yes 2□ No
certificate rector, pag		25. Was cese referred to medical 26.	. Plece of Death	(Check only one	)		
		Handtol.	-	me 5 Residen		r (Specify)	
After this funeral di	2	27. Manper of Deeth 28a. Dete of Injury 28b. Time of 28c. Injury at		28d. Describe hov			
death. ctor: Af y the fu y ficatio		1 ☐ Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes	2 🗆 No				
within 24 hours effer death. To the Funeral Director: Affer to completely filled in by the funeral Medical Certification:		3 ☐ Suicide 4 ☐ Homicide  Could not be determined  28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)	4	28f. Location (Stre City or Town,		or Aural	Routa Number,
he Funer pletely fill edical	2	29e. Certifier (Check only one)  1 ☐ Certifying Physicien: To the best of my knowledge, death occurred et the time, da 2 ☐ Medical Exeminer: On the bests of examinetion end/or investigation, in my opinion end manner steled.	ate and piece, e	and due to the ceu ad at the time, det	use(s) end mar le end piece, e	ner es sta nd due to t	ted. he ceuse(s)
ithin ithin male	2	29c. License num	mber	200	d. Dete signed	(Month D	av Vaarl
≥ ⊬ 8	•	JEM MAD					uj, 1001)
		DA5	750		5-7-	19	
	3	30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)				-	
		ROBERT B. SANCHEZ, M.D., 508 IDLEWILD AVENUE,	EASTON,	MD 2160	)1		
State	3	31. Date filed (Month, Day, Year)  32. Registrer's Signeture					
		ROBERT B. SANCHEZ, M.D., 508 IDLEWILD AVENUE,			3-7-1 01	89	

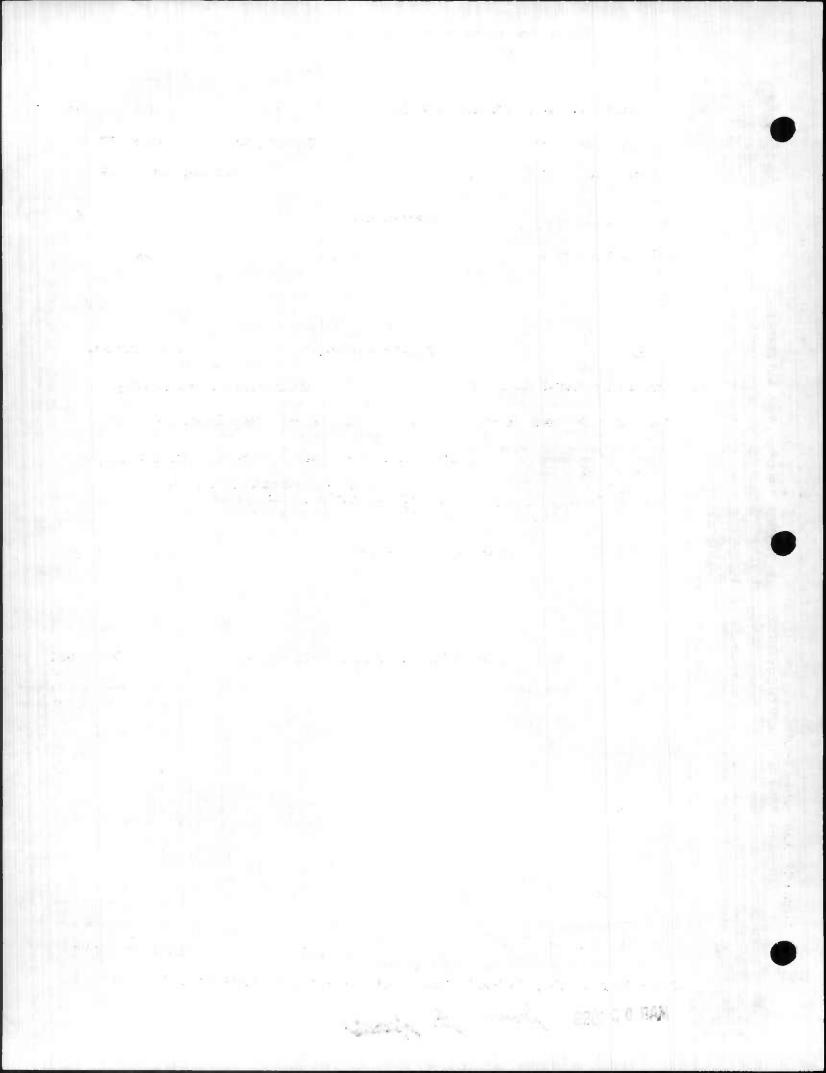


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Neme (First, Middle Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 1999 CLARENCE BERNARD ARTIMUS KEAN, SR. March 2, 3:41 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street and number) **Examiner** ALLEGANY MEMORIAL HOSPITAL CUMBERLAND 8. Date of Birth (Month, Day, Year) Mar 13, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 PA 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Min Months Hours XDM 2DF Yrs. 91 214-07-2020 Director Usual Residence of Decedent with the Marylend 10d. Inside City Limits 10a. Stele 10b County 10c. City. Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Madical Examinar must be notified as Yas 2 No Director Cumberland MD Allegany 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or frems 23a and Injury or other traumatic event, the Medical Experiments. 603 Hilltop Drive 21502 Funeral 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Bleck. White, etc. 1 Yes X No 1 Never Merried 2 Married 1□ Yes X□ No Specify: Specify by 3€ Widowed 4 Divorced Yeer or Detes white Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Tire Company Chemist/Compounder 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Richard Bernard Burton Kean Elizebeth Hannah (Stucky) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 603 Hilltop Drive; Cumberland, MD Clarence B.A. Kean Jr.-son Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 Donetion 5 Other (Specify) Sunset Memorial Park 03/04 Cumberland, MD 22. Name end Address of Fecility ufb of Funeral Sefficion Licenses Scarpelli Funeral Home, P.A. Cumberland, MD 21502 23a. Pert1. Enter the disease, or complications that caused the shock, or heert failure. List only cause on each line. enter the mode of dying, such as cardiec or respiretory errest, Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) BLEED GASTROINTESTINAL BLEED 1 DAY Examiner Due to (or as a consequence of) Examiner requires that the deeth certificate be executed ettending physician end for use as the burial-tran Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Vital Records. P.O. Box 68760. Physician/Medical Due to (or es e consequence of) >15 YEARS CHRONIC OBSTRUCTIVE PULMONARY DISEASE signed by the eld be detached f 23b. Did tobacco use contribute to the causa of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 ₺ Unknown P 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy peen ΜĐ pege 2 hes The 2 No 1 Yes 2 No 1 Yes certificate Physician: Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 Yes 2 No 11 Inpatient 2 ER/Oulpelieni 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 Division of this funeral 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? Certification: After or Attending 1 Neturel 5 Pending 1 Yes 2 No the Funeral Director: A investigation death. 2 Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide 29e. Certifier 🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and menner as stated. Medical completely (Check only one) 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Within 2 To the 29d. Dete signed (Month, Day, Year) 29b. Signetare end mile of certifier 29c. License number 1999 D 23371 March 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) JOHNSON HEIGHTS MEDICAL BUILDING CUMBERLAND MD 21502 QAMAR ZAMAN, M.D., 31. Date filed (Month, Day, Year) 32. Registrer's Signature State MAR 0 3 1999 Registrar ALCOHOL:

**DHMH 16 Rev 6/95** 

CLARENCE KEAN



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Date of Death FEBRUARY 28,1999 **Physician** ROBERT WALTER KOELKER SR. 16:10 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** Days Hours 1**X** M 2□ F Yrs. Director JULY 31 1925 MARYLAND 218-16-2608 Usual Residence of Decedent deeth with the Marylend permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Marylen Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Example must be notified at page. 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 X Yes 2 □ No CUMBERLAND MARYLAND ALLEGANY Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 158 BEDFORD STREET 21502 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩ 1 1 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) PITTSBURG PLATE GLASS CO 8 GLASS CUTTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) JOSEPH H. KOELKER ADA LAYMAN 19a. Intormant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY U. KOELKER WIFE 158 BEDFORD STREET CUMBERLAND MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State CUMBERLAND CREMATORY MARCH 2, 1999 CUMBERLAND MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Fecility
MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND oc. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 6 HOURS SEPTIC SHOCK Examiner Due to (or as a consequence ot): Examiner 2 YEARS CELL CA OF LUNG WITH WIDESPREAD METASTASIS SMALL ettending physician and for use as the bunal-transit death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence ot): COPD Box 68760. Physician/Medical Due to (or as a consequence ot) use as 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting In the underlying ceuse given in Part I. the signed by 1 Yes 2 No 3 Probably 4 Unknown à Division of Vital Records. 24b. Were eutopsy tindings available prior to completion of cause ot death? Completed 24e. Wes an eutopsy performed? certificata has 2. No 1 ☐ Yes 1 Tyes 2 No director. 25. Was cese reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 1 Inpatient this funeral 27. Manner of Deeth 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? After Certification: Attending Netural 5 Pending Investigation deeth. 1 Tyes 2 No 2 Accident after deetl Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tectory, office building, etc. (Specify) 6 4 Homicide ò Hospital 24 hours 29a. Certifier \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and Jitle of certifie 29c. License number MARCH 02,1999 D-17526 30. Name and address of person who completed cause of death (fight 23s) (Type, Print) Dh.S 902 SETON DRIVE, CUMBERLAND, MD 21502 JOHN MEHANNA, MD,

DHMH 16 Ray 6/95

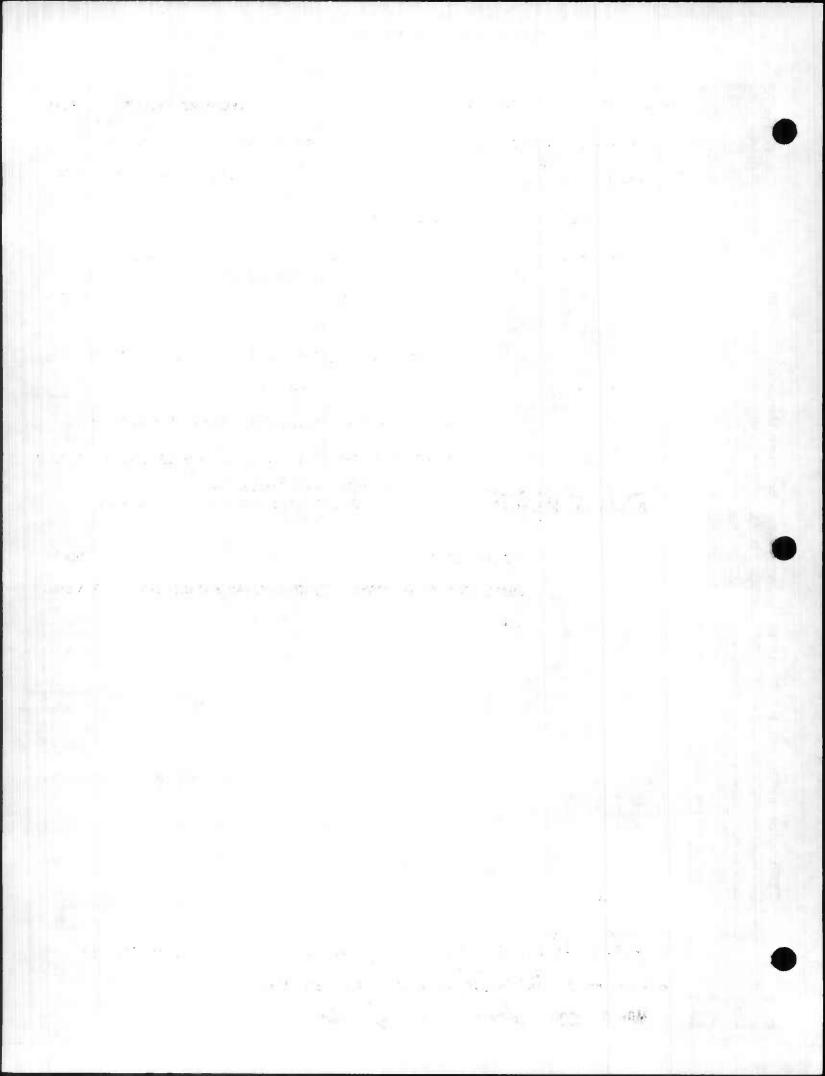
State

Registrar

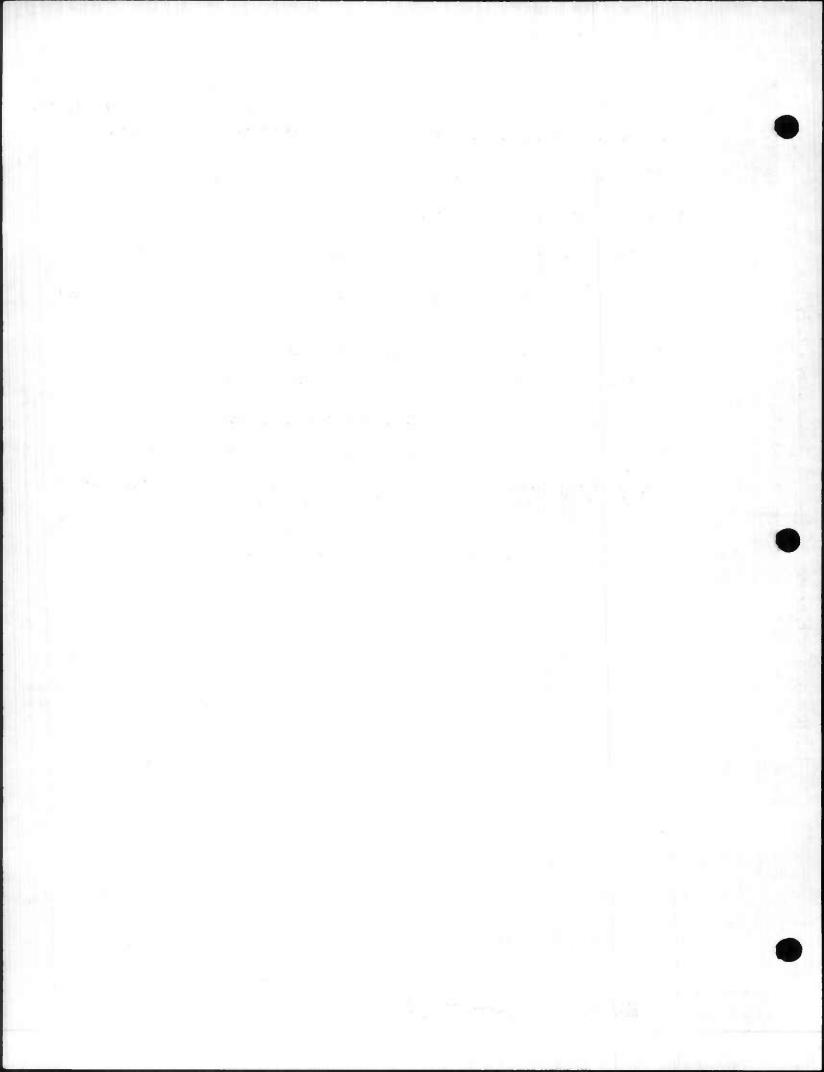
31. Date tiled (Month, Day, Year)

MAR 0 3 1999

32. Registrar's Signature



1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death Month **Physician** WITLITAM THOMAS KERNS 1632 , 1999 march /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth WICOMICO Examiner SALISBURY PENINSULA REGIONAL MEDICAL CENTER 5. Sociat Security Number If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Defe of Birth (Month, Dev. Yeer) Birthplace (Stete or Foreign Country) **Funeral** Months Days Hours 152M 2□ F Yrs. Director 220-24-7594 69 April 21,1929 Maryland Usual Residence of Deceden with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23s or 28s-f ehow other traumstic event, its Medical Examiner main be notified at Maryland Worcester Ocean City 1√2 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21842 USA 13333 Nantucket Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 No If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White à 3 ☐ Widowed 4 ☐ Divorced WW II Year or Dates: Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: If item 27 is merked other than any injury or other traumatic avant server. Elementery/Secondery (0-12) College (1-4or 5+) Pitney Bowens Service Representative 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Nora Cammer Bernard Joseph Kerns 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a, Informent's Neme/Relationship (Type, Print) Sherry Kerns/Wife 13333 Nantucket Rd., Ocean City, MD 21842 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete ₩ Burial 2 Cremetion 3 Removal from State 3/9/99 Hurlock, MD Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liq 22. Name end Address of Facility M01051 Holloway Funeral Home Professional Association 23a. Pert1. Enter the disease, or complications that faused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximete Interval Between Onset end Death Physiclan /Medical tmmediate Cause (Finat cardisvasculor disease Atheroschotic disease or condition resulting in death) Examiner Due to (or es e consequence of) certificate be axecuted buriei-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest and Due to (or es e consequence of): ettanding physician for use as the burie Physician/Medical Due to (or es e consequence of) 23b. Did tobecco use contribute to the cause of death? Part tl. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. by t 1 2 Yes 2 □ No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to completion of cause of death? Be Completed page 2 should 24e. Was en eutopsy performed' After this certificate hes 2 19 No 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28d. Describe how injury occurred Hospital or Attending Pt
 24 hours aftar deeth.
 Funeral Director: After the lataly filled in by tha funeral 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 12 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) and menner as steted.
2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and menner steted. Medical 29a. Certifier To the Fune complately fi (Check only one) the the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 0 41721 10×11A 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 400 Eastern Shore Dr. Salisbury Md. Stephan Pau 31. Date filed (Month, Day, Year) Paulos M.D. 32. Registrer's Signature State MAR 0 9 1999 Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 1 5

sician			C	ertificate of	Death		Reg. No.		
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ner	4e Fecility Neme (If not institution, ga					or Location of Deetl	,		
	HARBOR H	0417111	CEN			TIMORE			
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	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Detes: 1 C	945	1 ☐ Yes 2 🖾 No	Specify:		Specify	·: WH	ITE
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L	HARRY RUSS	EPP		TING		IARIAH		SMITH	
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	21. Signature of Foneral Service Libi	myso n n		22. Name end Addr	ess of Facility S	INGLETON	FUNERAL	HOME	, P.A.,
	· CVA	Select		1 SECOND	AVENUE,	S.W., GL	EN BURN	IE, M	D. 21061
	23a. Part1. Enter the disease, or cor shock for heart failure. List only	mplications that caused the de	ath. Do not	enter the mode of dy	ing, such es car	diac or respiretory e	rrest,		Approximete Intervel Between
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	thet initieted events resulting In death) Lest	Due to	(or es e cons	equence of):					
								1	
		d.						1	
	Pert II. Other eignificant conditions	contributing to death but not re	esulting In the	underlying cause g	iven in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of death
	HYPOTHYR	0101119				1)X(	Yes 2□ No	3 Prob	ably 4 ☐ Unkno
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State of Maryland / Department of Health and Mental Hygiene 0 0 0 0 1 c

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Testard Name (First, Models, Masclen Sumanns)  CHARLES KIRBY  198. Mother's Name (First, Models, Masclen Sumanns)  ANNIE KIRBY (MOTHER)  198. Malling Address (Served and Number or Paural Route Number. City or Town, State, Zp Code)  ANNIE KIRBY (MOTHER)  198. Malling Address (Served and Number or Paural Route Number. City or Town, State, Zp Code)  ANNIE KIRBY (MOTHER)  198. Malling Address (Served and Number or Paural Route Number. City or Town, State, Zp Code)  ANNIE KIRBY (MOTHER)  198. Malling Address (Served and Number or Paural Route Number. City or Town, State, Zp Code)  ANNIE KIRBY (MOTHER)  108. Malling Address (Served and Number or Paural Route Number. City or Town, State, Zp Code)  209. Name and Address of Paural Route Number. City or Town, State, Zp Code)  21. Signature of Furnaria Service Licenses  WILSON MEM. CERETERY (3 /6 /9 9)  22. Name and Address of Facility  WILSON MEM. CERETERY (3 /6 /9 9)  23. Signature of Furnaria Service Licenses  WILSON MEM. REESE & SONS MORTURY, P.A.  22. PRIST ST. ANNAPOLITS, MD. 214.01  23. PRIST Code Anna Address of Facility  Inmediate Causa (Final Institute Licenses)  18 Nouth (1998)  24. Wes an autopsey performed?  24. Wes an autopsey performed?  25. Place of Death (Check ring) and a consequence of)  26. Place of Death (Check ring) and a consequence of Code and Death (Check ring) and a consequence of Code and Death (Check ring) and a consequence of Code and Death (Check ring) and a consequence of Code and Death (Check ring) and a consequence of Code and Death (Check ring) and a consequence of Code and Death (Check ring) and a consequence of Code and Death (Check ring) and a consequence of Code and Check (Check ring) and a consequence of Check (Check ring) and a consequence of Check (Check ring) and Check (Check ring)	nple			life.	DO NOT use retii	red)	Urking		
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Commission   Chemeroval from State   Commission   Commi		ANNIE KIRBY (MC				R DR. S	EVERN,	MD. 21	144
21. Signature of Funeral Service Licensaa  22. Nama and Address of Facility  WM. REESE & SONS MORTUARY, P.A.  239. Part I. Enter the displase, or completion that caused the death. Do not enter the mode of dying, such as cardac or respiratory arriest.  Conset and Death  Immediate Cause (Final resulting in death)  Sequentially list conditions, cause of each line.  B. Cerebra Nanapolitis, and the caused of the cause of t		1 ØBurial 2 ☐ Cramation 3 ☐	Removal from State	cematery, crei	matory or other p				
239. Part I. Enter the displess, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Part I. Enter the displess, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Immediate Causa Final disease or conditions of the conditions of				22	2. Nama and Add	ress of Facility			
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Immediate Causa (Final disease or condition rasulting in death)   But to (or as a consequence of):		shock, or haart failura. List only	ona causa on each lina.			,			Interval Between Onset and Dea
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Socientially list conditions, all any leading to immediate dause. Enter Underlying that inflited devenir trasulting in death) Last  Due to (or as a consequence of):    Due to (or as a consequence of):		disaasa or condition							18 4041
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   Yee 2   No 3   Probably 4   Unix	9		Dua to (	or as a conseq	uence of):				
24a. Wes an autopsy performed?  24b. Were autopsy finding available prior to completion of cause of death?  1   Yas 2   No			d						
24a. Wes an autopsy performed?  24b. Were autopsy finding available prior to completion of cause of death?  1	la								
24a. Wes an autopsy performed?  24a. Wes an autopsy performed?  24b. Were autopsy finding available prior to completion of cause of death?  1	Sic	Part II. Other significant conditions of	ontributing to death but not ra	sulting in tha u	nderlying causa (	given in Part f.	23b. Did	tobacco use co	ntribute to the cause of d
25. Was case referred to medical axaminar?		Hypertensi	) N				10	Yes 2□ No	3⊠Probably 4□Uni
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27. Menner of Deeth 1. Natural 2   Accident 3   Suicida 4   Homicide  28a. Plece of Injury - At homa, farm, street, factory, office 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Signafura and titla of certifier  29b. Signafura and titla of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)  M. Murshing Nome 28d. Describe how injury occurred 28d. Location (Street and Number or Bural Routa Number, City or Town, Stata)  28d. Location (Street and Number or Bural Routa Number, City or Town, Stata)  28d. Describe how injury occurred 28d.		axaminar?	Hospitel:	7500 4000	C	Wher			
1 Natural 2   Accident   1 Natural 2   Accident   1 Natural 2   Accident   1 Natural 2   Accident   1 Natural 3   Suicida 4   Homicide   28a. Plece of Injury - At homa, farm, street, factory, office   28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)   29a. Certifier (Check only one)   29a. Certifier (Check only one)   29a. Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated.   29b. Signatura and titla of certifier   29c. License number   29d. Date signed (Month, Day, Year)   29b. Signatura and titla of certifier   29c. License number   29d. Date signed (Month, Day, Year)   30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)   M. Mwaisela M. Dept. of Neurology, UTIMS, 22 S. Green St., Baltimore M.D. 21201	-		28e. Dete of friury	1	II JU DOA	4 LI Nursing	7		
29a. Certifier (Check only one)  29a. Certifier (Check only one)  12 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.  29b. Signafura and titla of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)  M. Mwatsela MD, Dept. of Neurology, UTIMS, 22 S. Green St., Baltimore MD 21201	Į,	1⊠Natural 5 Pending	(Month, Day Year)				200.000.00		
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signafura and titla of certifier  29b. Signafura and titla of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)  M. Mwaisela MD, Dept. of Neurology, UMMS, 22 S. Green St, Baltimore MD 21201	rtifica	3 Suicida 6 Could not b	homa, farm, str ify)						
29b. Signatura and titla of certifier  Warella Mwk tela WD  AU4176435-M8743 3/2/1999  30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)  M. Mwaisela MD, Dept. of Neurology, UTIMS, 22 S. Green St, Baltimore MD 21201		(Check only 2 Medical Exer	niner; On the basis of axamin	owledge, death	n occurred at the vestigation, in my	time, date and pla-	ce, and due to the curred at the time,	cause(s) and me date and place,	unner as stated. and due to the cause(s)
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30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print) M. Mwaisela MD, Dept. of Neurology, UMMS, 22 S. Green St, Baltimore MD 21201		Marela M	Watcha Wi	D	AU4	176435-	-M8743	3/2/	1499
		30. Name and addrass of person who	complated causa of death (Ite	m 23a) (Type,	Print)				
		M. Mwaisela MD, Dep	t. of Neurology, L	LMMS, 2	2 S. Gree	n St, Ba	Himore	MD 212	201
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State of Maryland / Department of Health and Mental Hygiene 9

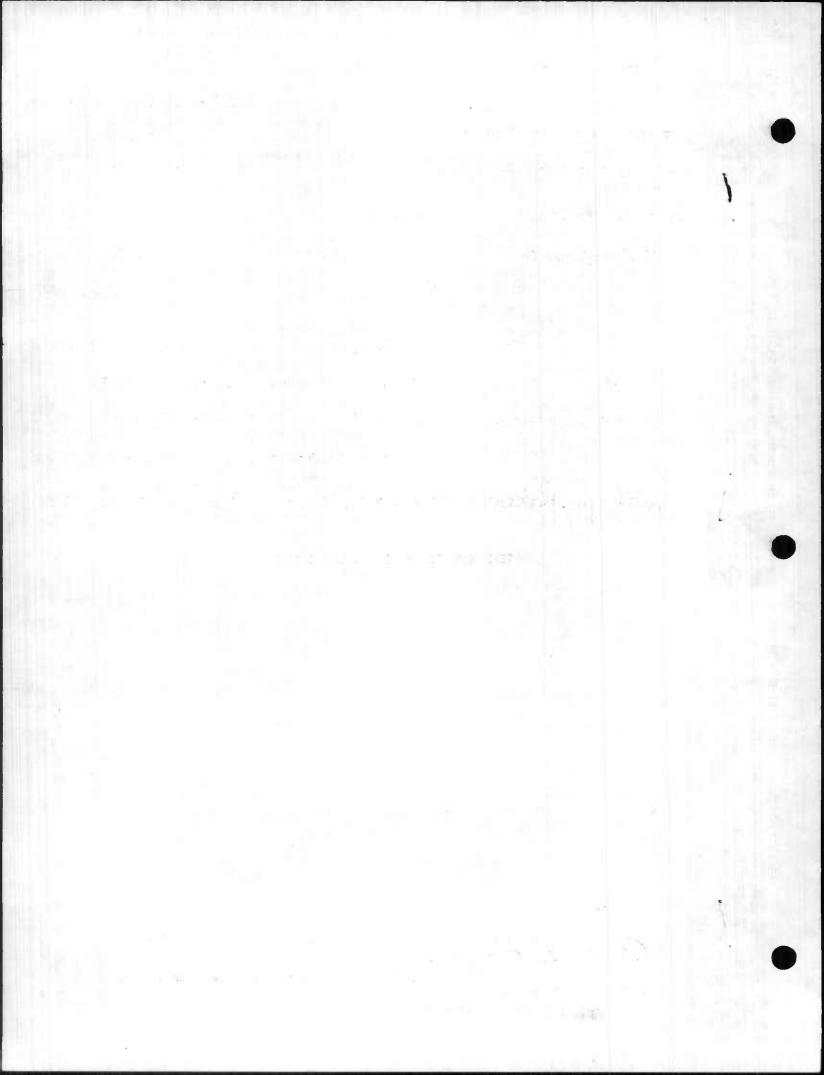
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** KIMBLE 7:35 Am ELWANDA 1999 mage H /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HAIBOR HOSPITAL CENTER BALTIMORE If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2♥F **Funeral** 21334 1883 Usuel Residence of Decedent 65 Yrs. JULY 28, 1933 WEST VIRGINIA Director with the Marylend r 28a-f ahow 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MARYLAND ANNE ARUNDEL BROOKLYN PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or edical Exercises must be 5601 PATRICK HENRY DRIVE 21225 U.S.A. Peges 1 and 2 should be filed within 72 hours after death nent of Heelth and Mental Hygiene.
This if items 27 Is marked other than "natural", or items 23, mit; if item of the unadic event, the file Exercise Training or other Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: WHITE py 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working lifte. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 MORTGAGE CLERK BANKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BERLIN McDONALD ADA LAHMAN 19b. Mailing Addreas (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) DEBBIE K. KIMBLE (DAUGHTER) 5601 PATRICK HENRY DRIVE, BROOKLYN PARK, MD. 21225 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Locetion - City or Town, Stete MXBurial 2 Cremation 3 Removel from State Depertment of Important: If any Injury or MAYSVILLE CEMETERY 3/10/99 MAYSVILLE, WEST VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 complications that laused the death. Do not enter the mode of dylng, such es cardiac or respiratory arrest, only one couse on each line. Approximate Interval Between Onset and Death **Physician** immediate Ceuse (Final disease or condition resulting in death) /Medical PNEVMONIA DAYS Examiner Due to (or es a consequence of): Examiner MONTHS SMOKE physician end the buriel-transit thet the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es a consequenca of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown END SM GE REMAL DISEASE been signed should be det Division of Vital Records, 2 CAPULT POLYCYSTIC KIPNEY DISEASE) 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed ate hes 1□ Yes 2 10 No 1 □ Yes 2 □ No certificate or Attanding Physician: funeral director. 25. Was cese referred to medical Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatlenf 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No 2 After this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending efter death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide filled in 24 hours e Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) and manner as steted. Medical completely (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D29296 seind m - mo MARCH 1999 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Crand m Lomiemb 901 BALTIMORE, MARYLAND 21230 EAST FORT AVENUE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 8 1999 Registrar

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DHMH 16 Rev 6/95

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1. 0	AL ITEMS: #23 recedent's Name (First, Mi								2. Date of E			3. Time of Death
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	Facility Neme (If not institu 'REDERICK MEN						1	FREDER			ty of Death	
	ocial Security Number 578-82-2145		7. M 2 F	Age (In yrs.	lest birthdey) Yrs.	If Und Month	ler 1 Year s Deys	If Under 24 Hrs Hours Min		lirth Dey, Year) 1962	9. Birthplec Country, IIIII	e (Stete or Foreign OIS
	al Residence of Decedent Stete 10b. Cou			10c. Cit	y, Town or Lo	cation					10d.	Inside City Limits
Ma	aryland Fr	ederi	.ck		reder							1 🖾 Yes 2 🗆 No
109	Street end Number					10f. 2	Zip Code			10g. Citizen of	Whet Country	?
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	Meritet Status 1  Never Married 20 N 3  Widowed 4 Divord	farried	12. Was Decede Armed Force 1 N Yes 2 If Yes, Give Year or Date	<sup>s?</sup> № 198	30-	If Yes, s	edent of Hoecify Cuba 2 X No	ispanic Origin? (S in, Mexicen, Puer Specify:	Specify Yes or Note Rican, etc.)		ace - Americen ack, White, etc ify: Whit	
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21.	Signature of Funeral Serv	ice License	Bener	) WOO.		Ke	eney	& Basfor hurch St				1 21701
236	. Part . Enter the discase shock, or heart failure. I	or compli	cations thet ceu			ter the m	ode of dyin	g, such es cardla	c or respiretory	errest,	A	oproximate tervel Between
Sec if ai ceu Ceu	pase or condition ulting in death) juentially list conditions, ny, teeding to immediate se. Enter Underlying initiated events	{ ·	ARTERIO	Due to (d	or as a consecutive or es ablished o	quence d	f):	DISEASE				
res	ulting In death) Last		l									
Post	II Other plantileant cons	itiana con	tributine to dont	but not so	ulting in the co			on in Post i	22h Di	d tobecon use o	ontribute to th	e ceuse of death?
ren	II. Other significent cond	ittions con	irrouting to deati	n but not res	ulling in the u	повнун	j ceuse giv	en in ranti.		Yes 2 No		./
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					- M				24a. We	es en eutopsy rformed?	24b. Were evalia comp of dec	eutopsy findings ble prior to letion of cause eth?
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				diam's P.ST	ED/O. 44		Oth Oth	26. Piece of De er:			When (Const.)	
25.	Was cese referred to med		lospital:		ER/Outpatie		28c. Injur	4 🗆 Nuising	1	sidence 6 🗆 O e how injury occi		
27.	examiner?  1. Ves 2 No  Venner of Deeth  1. Notural 5 Per	Н	lospital: 1 Inp. 28e. Dete of t (Month,	.032	28b. Time o Injury	М		Yes 2 □ No				
27.	examiner?  1.	H	28e. Dete of t (Month,	njury Dey Year)		М	10		28f. Location City or T	(Street end Nun Town, Stete)	n <i>ber or Rural R</i>	loute Number,
27.	examiner?  15 Yes 2 No  Menner of Deeth  16 Natural 5 Per  2 Accident inve  3 Suicide 6 Cou  4 Homicide det	ding estigation ald not be ermined	28e. Place of building,	Injury - At hetc. (Special	Injury ome, farm, sti	M reet, fact	1 ory, office		City or T	fown, Stete) se ceuse(s) and r	menner es stete	ed.
27.	examiner?  1 New Service Servi	ding estigation ald not be ermined lying Physical Examin	28e. Date of the Month, 28e. Place of building,	Injury - At hetc. (Special	Injury ome, farm, sti	M reet, fact n occurre vestigeti	ory, office  ed et the tin on, In my o	Yes 2 No	City or T	ne cause(s) and re, dete end place	menner es stete e, and due to th	ed. e ceuse(s) y, Year)
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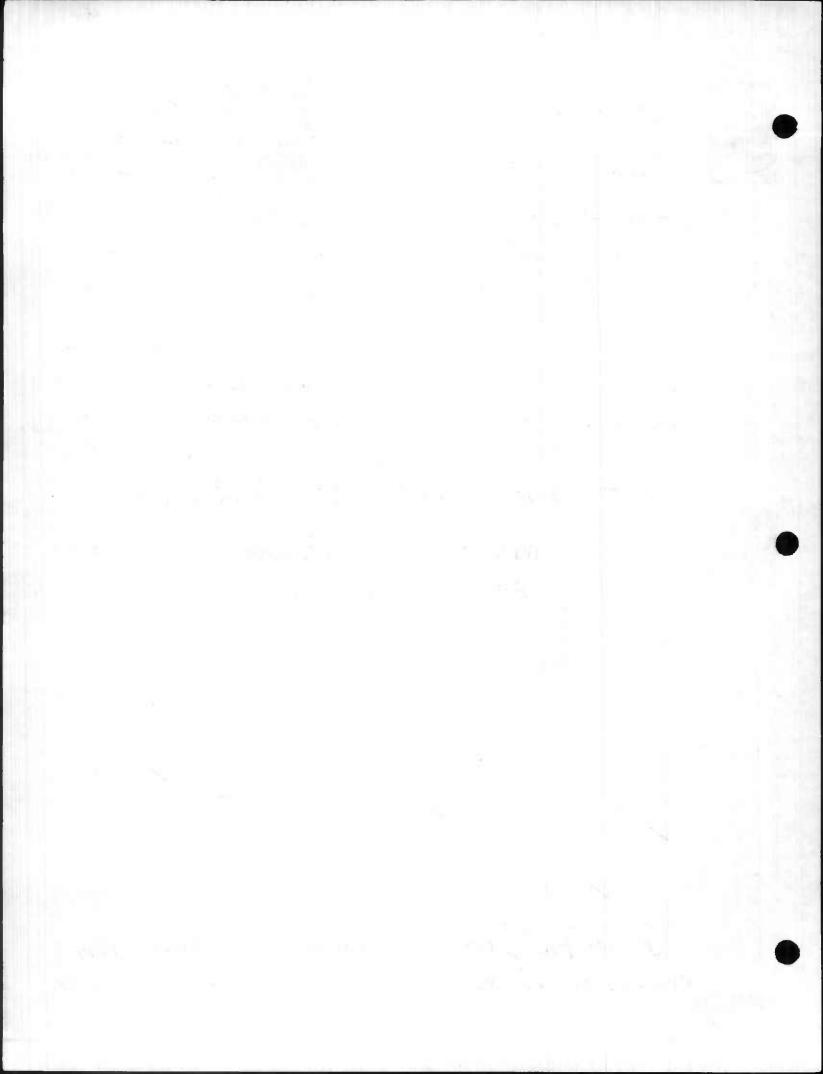


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State of Maryland / Department of Health and Mental Hygien 9

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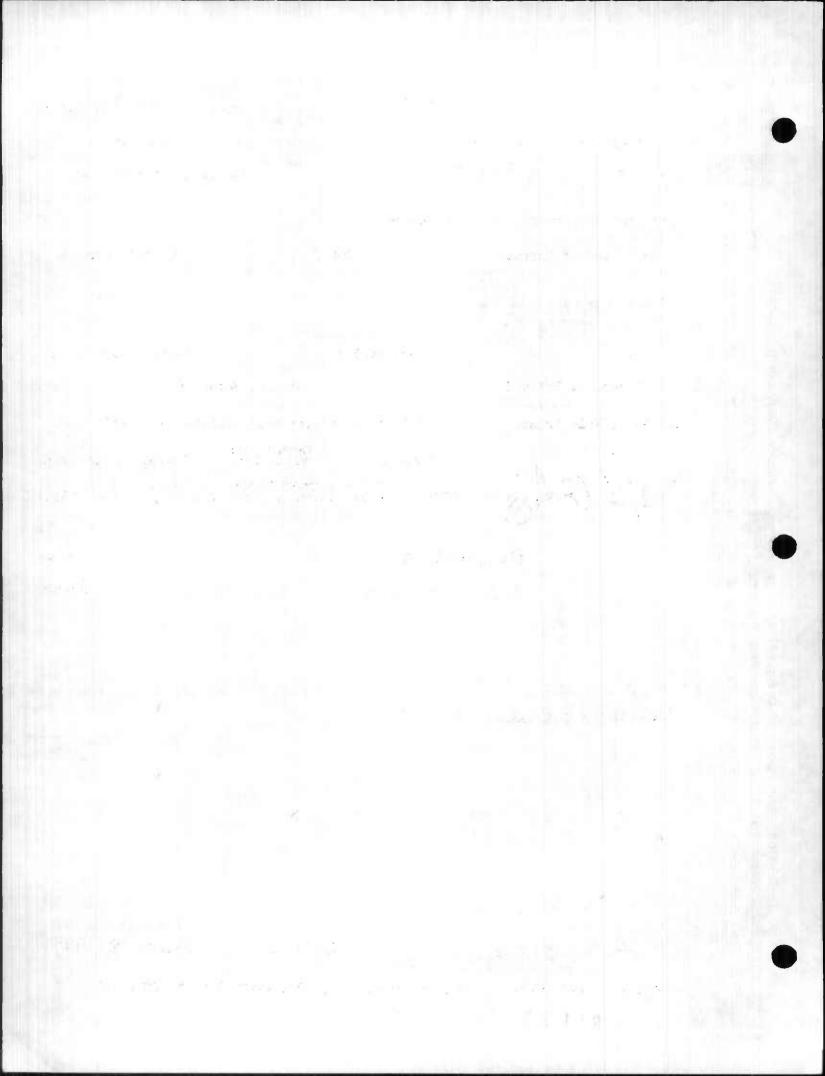
		1. Decedent's Name (First, M	iddle, Last)			00	rtificate	UI	Dealli	2. Date of De	Reg. No.		3. Time of Death
Physic		CLAIRE KAY		NCE						Month MARCH	Day	Year	2:20PM
/Medi Exami		4a. Fecility Name (If not instit			er)				4b. City, Town, or L			y of Death	Z:ZUPM
LAGIIII	iici	HOLY CROSS HO							SILVER SP	RING		OMERY	7
Funeral	ľ	5. Social Security Number	6. Sex	7.	Age (In yrs. I	ast birthdey)	If Under 1	Year	If Under 24 Hrs.	8. Date of Bi	rth		
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ath with the Maryle 23s or 28s-f show	to	MARYLAND MONT	GOMERY			SI	LVER S	SPR	ING				1 ☐ Yes 2 🛈
or 28	Director	10e. Street end Number					10f. Zip C	ode			10g. Citizen of	What Coun	itry?
th wi		10700 WOODSDA	LE DRI	VE			2	209	01		UNITED	STATE	S
72 hours after death with the Maryland "naturel", or items 23s or 28s-f show idical Examination must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2(🔀) 3 □ Widowed 4 □ Divor	Married	. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	No		Was Deceder f Yes, specify 1 ☐ Yes 2 Ø		Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	14. Ra Bla Speci	ca - Americ ick, White, fy: BLA	etc.
72 ho	ted	15. Dece	dent's Educa	tion		16a. Deced	dent's Usuai (	Occup	pation	la a	16b. Kind of E	Business/Inc	dustry
S	Completed	(Specify only his Elementary/Secondary (0-1		College (1-4	or 5+)	life. I	DO NOT use	retire	during most of work d)	ing			
	00			5+		Γ	EACHER	3			PUBL]	C SCF	IOOLS
	Be	17. Fether's Name (First, Mid	fle, Last)						18. Mother's Nam-	e (First, Middle	, Meiden Suma	me)	
	2	ERNEST RAINFO	RD						MARY KAY	DODDY			
0 0 0 0		19a. Informant's Name/Relati					-		end Number or Run				
f Health them 27		DWIGHT LAWREN	CE/HUS	BAND	1			_	LE DRIVE				
0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremati	on 3 □Ren	noval from Sta	20b. Pl	ace of Dispo metery, cren	sition (Neme netory or othe	of er ple	ca)	Date	20c. Location	- City or To	wn, State
men		4 Donetion 5 Othe				OF H					SILVER	SPRIN	IG, MD
permit. Pag Depertment Important: I any injury o once.	-	21. Signature of Funeral Serv	ice Licensee	_		22 H T	NES-RI	Addre	ess of Facility LDI FUNER	AT HOMI	F. INC		
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tificate be executed grows and es the burial-trensit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events	<b>J</b> .									i i	
sare the the the the the the the the the th	dice	that initiated events resulting in death) Last	0		Due to (or	as a conseq	uenca of):			_			
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death cert e ettendin ed for use	Physician/Medical		- 0.										
0 0 0	sic	Part II. Other significant cond	ittions contril	buting to deat	h but not resu	ting in the ur	nderlying caus	se giv	en in Part I.	23b. Did	tobacco usa co	entributa to	the cause of de
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cartificata rector, pag		25. Was case referred to med	ical						00 Dt		Yes 2 No	16	Yes 2 No
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Artending ir death. Detor: After by the funa	Į.	1 PNatural 5 Per 2 Accident inv	ding estigation	(Month,	Dey Year)	Injury	М		rk? Yes 2 □ No				
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aftar Direct	en	4 Homicide		building,	etc. (Specify)					City or To	wn, Stete)		
violube Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cartific complately filled in by the funaral director,	edical C	29a. Certifier 1 Certifier (Check only one) 1 Medical	ying Physici cal Examiner	an: To the be : On the basis and manner	of examination	ledge, death on and/or inv	occurred at trestigetion, in	the tir	me, dete end piace, ppinion, death occurr	and due to the ed at the time,	cause(s) end m date and piaca,	anner as st and due to	eted. the cause(s)
vithin of the	Me	29b. Signature and title of cer	mar /	11			29c. L	icens	se number		29d. Date signe	ed (Month, I	Dey, Year)
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6		30. Name and address of per	Sem		d dooth //	02a) /T.mr. 1	Deigh	7	104 hive Aug		ium	2/17	17
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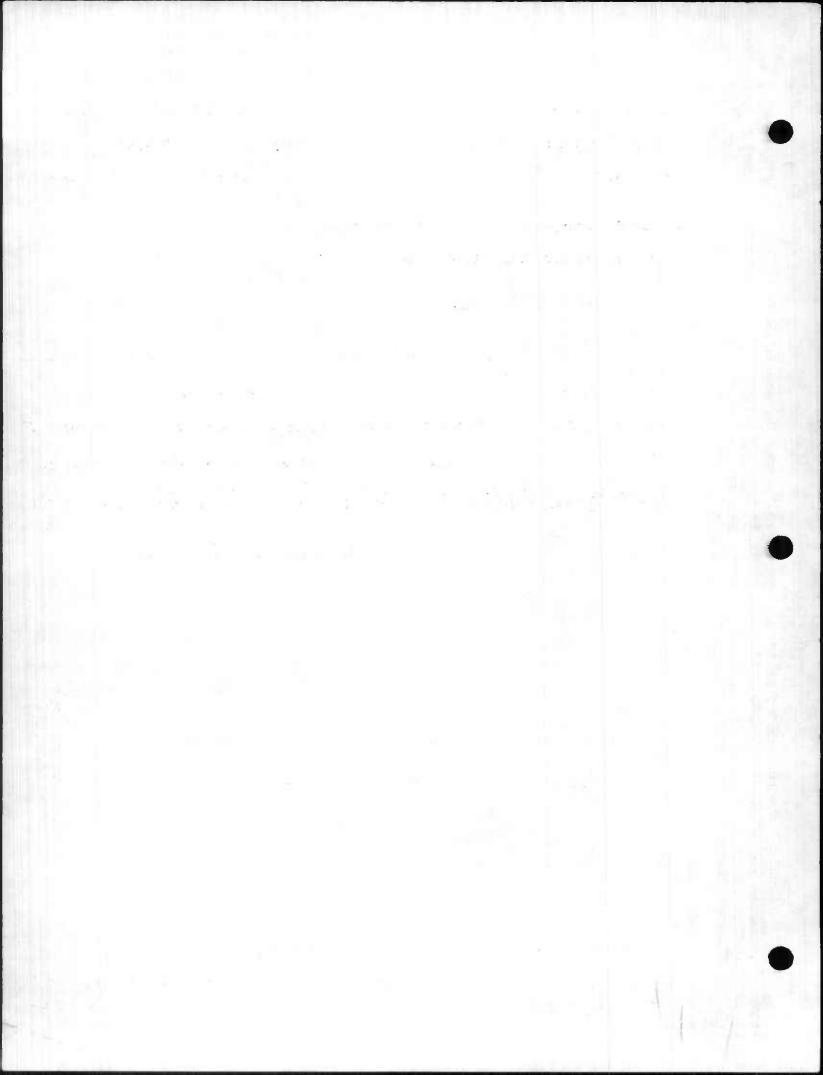
State of Maryland / Department of Health and Mental Hygiene 99 09220

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-		b. County		10c. Ci	ty, Town or Lo	ocation						10d. Insida Cli
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	3 X Widowed 4 □	Divorced	Yaar or Da	itas:				opcon,		Орв	ony. WI.	1166
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	Samue	1 H. Wo	lford					Anna	E. Bensh	uff		
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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

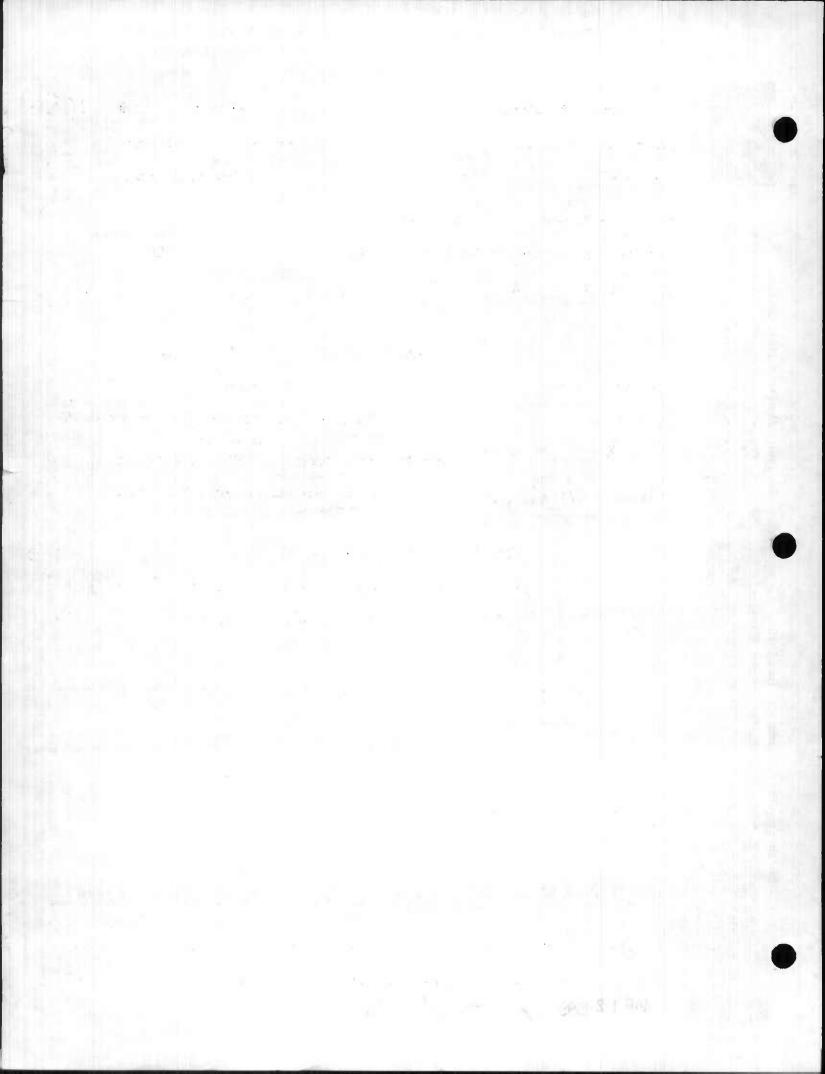
	Otate of	Certi	ficate of Dea	th	Reg. No.	09221
Dhualaian	1. Decedent's Neme (First, Middle, Last)			2. Dete of De Month	eth Dey Ye	3. Time of Death
Physician /Medica	Harold L. Lowder				1999	12:20 PM
Examine	4e Facility Neme (If not institution, give street end numb	er)	4b. City,	, Town, or Location of Deat	4c. County of E	
	Montgomery General Hospi			ney	Montgom	nery
Funeral	5. Sociel Security Number 6. Sex 7.	Ngo (mr yro: root om tracy)	f Under 1 Year If Und	der 24 Hrs. 8. Dete of Bir rs Min. (Month, De	th y, Year) 9.	Birthplece (State or Foreign Country)
Director	236-18-318/	77 Yrs.		June 4,		st Virginia
P ≥	Usuel Residence of Decedent  10e. Stete 10b. County	10c. City, Town or Locat	ion			10d. Inside City Limits
lanyle						1 ☐ Yes 2√ No
d 21215-0020  filed within 72 hours after death with the Manyand thygiene.  ther than "naturel", or flows 23a or 28a-f show mit, the Modical Examination must be incurised at Commissional Disorder.	Maryland Montgomery  10e. Street end Number	Silver	Spring 10f. Zip Code		10g. Citizen of What	t Country?
with po d						Country
fier death w	2921 North Leisure World  11. Meritel Status 12. Wes Decede		20906	Origin? (Specify Yes or No	USA 14 Rece - A	American Indien,
ter dea	Armed Force	es? If Yo	es, specify Cuben, Mexi	Origin? (Specify Yes or No ican, Puerto Rican, etc.)	Bleck, V	White, etc.
21215-0020 d within 72 hours after designation instured, or items the Medical Examiner in the Medical	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 If Yes, Give Yeer or Dete	1 DS: 1.TL T T	Yes 2☑ No Spec	oify:	Specify: W	hite
-O-O-O-O-O-O-O-O-O-O-O-O-O-O-O-O-O-O-O	15. Decedent's Education		t's Usuel Occupetion		16b. Kind of Busine	
od within 72 ho ygiene. Nor then "nature. It, the Medical	(Specify only highest grede completed)  Elementery/Secondary (0-12) College (1-4)	(Give kin life, DO	t's Usuel Occupetion d of work done during n NOT use retired)	nost of working		
d withir giene.	4		Processor		Newspape	r
und 212: be filed within tai Hygiena. d other then event, tre. H				other's Neme (First, Middle		
should be filed and Mental Hygi marked other immite event, I	John G. Lowder			Katherine Je	nks	
	19e. Informent's Neme/Relationship (Type, Print)	19b. Malling /	Address (Street and Nu	mber or Rural Route Numb	er, City or Town, Ste	te, Zip Code) 20906
C = W F	Doris C. Lowder (					ver Spring,MD
altimore, N mit. Pages 1 and partment of Health portant: if than 27 yinjury or other 27	20e. Method of Disposition	20b. Plece of Disposition	on (Neme of ory or other piece)	Date	20c. Location · City	or Town, State
Pages nent of Int: If Its	1 2 Burial 2 □ Cremetion 3 □ Removel from St. 4 □ Donetion 5 □ Other (Specify)		ven Cemete	ry 03/8/99	Silver Sn	ring,Maryland
Baltim pemit. Pa Departmen Important: any injury pnce.	21. Signeture of Fyre rel Service Licensee	22. N	ame end Address of Fe	ecility		
Depa Impo any ii	Marya Yuta	Home, In				
	23a. Pert1. Inter the disease, or complications that cau	sed the deeth. Do not enter t	he mode of dying, such	Blvd., W., Si	.Iver Spri	Approximete
Physician	shock or heart failure. List only one ceuse on eed	h line.				Intérval Between Onset and Deeth
/ /Medical	Immediate Cause (Finel disease or condition	5	8:106	ral Pr	umomi	
Examiner	resulting in death) e.	Due to (or as e conseque		114	umomy	211
axecuted axecuted ial-transit	Sequentielly list conditions.	Due to (or es e consequer	nca of):			
O, as a same an	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury c.					
I Records, P.O. Box 68760, The lew requires that the death certificate be associted the has been signed by the ettending physician and page 2 should be detached for use as the burial-transit Completed by Physician/Medical Examir	that initieted events resulting in death) Lest	Due to (or es e consequer	nce of):			
ng ph						
Box (  Bath certif ettending for use a	d					
P.O. Box at the death cert dby the ettending etached for use a Physician M.	Pert II. Other significant conditions contributing to deat	h but not resulting in the unde	riying cause given in Pe	ert I. 23b. Did	tobacco use contrit	bute to the cause of death?
that the de detached in Prysic	0	4		10	Yes 2 No 3	Probably 4 Unknown
S, F as tha as tha igned be de	1 crni cions	memia				
v require been signaled should be	Pernicions Poly cy themia	Vera		24a. Wes	en autopsy 2.	4b. Were eutopsy findings aveileble prior to
The lew requir						completion of cause of death?
The lew ate has page 2	Humica vo	84: catom?	failm	10	Yes 2 No	1 Yes 2 No
	25. Wes case referred to medical	p   Rockey	26. P	lece of Deeth (Check only		
	exeminer? 1 Yes 2 No Hospitel: 1 Nop	atlent 2 ER/Outpetient	Othor	Nursing Home 5 Resi		Specify)
Physer this seral di	27. Menner of Deeth 28e. Dete of	njury 28b. Time of	28c. Injury et Work?		how injury occurred	-,,/
ion ath.: Afte	1 Maturel 5 Pending (Month, 2 Accident investigation	Dey Year) tnjury	M 1 Yes 2	2 □ No		
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Division of the state of the st	4 🗆 nomicide building	etc."(Specify)		City of 10	wn, Stete)	
Division Hospital or Attending 24 hours after death. Funeral Director: After staby filled in by the fune	29a. Certifier (Certifying Phyeician: To the be					
he Hosplin 24 hours he Funer pletaly fill pl	(Check only one) 2 Medicat Examiner: On the basi end manner	s of examinetion and/or invest steted.	tigetion, in my opinion,	deeth occurred et the time,	dete end place, end	due to the cause(s)
Division  To the Hospital or Attending F within 24 hours after death.  To the Funeral Director: After completaly filled in by the funer Medical Certification:	29b. Signeture end title of cartifier		29c. License numb	per	29d. Dete signed (M	fonth, Day, Year)
	G. Gupta, m	)	D 46	398	March 1	5, 1999
1041	30. Neme end eddress of person who completed cause			0		1
	G. Gupta, mo.	121 conque		Vano \$ 400	a, ROCK	20 F5 L
State	31. Dete filed (Month, Day, Year) 32. Red	istrer's Signeture	1	1 11	1	2000
Registrar	MAR 0 9 1999	pera 19.	sparks			LUTSL



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State of Maryland / Department of Health and Mental Hygiene 9

Physician /Medical Examiner					Certi	ficate of	Death		Reg. No.	D too the line
Examiner		ma (First, Middle, Las JOHN EARL	LEAKE					2. Data of Dea Month MARCH (	Day 19	
	A TAPE OF THE PARTY	(If not institution, give		)				r Location of Death	4c. County	of Death
uneral	Sacred I			ge (In yrs. las	A	f Under 1 Year	Cumberla If Under 24 Hr Hours Mir	s. 8. Date of Birt	Allega h y, Year)	9. Birthplaca (State or Fo
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wow.	10a. State	10b. County		10c. City,	Town or Locat	ion				10d. Insida City Li
mined ctor	MD	Allegany	Į.	Lona	coning					1 □ Yas 20
r frome 23e or 28e-fish from must be notified funeral Director	10e. Street and No.	<sub>umber</sub> 1d Coney (	Cemetery 1	Road SI		10f. Zip Code 21539			10g. Citizen of W USA	hat Country?
b y		rriad 2 Married	12. Was Decedan Armed Forcas 1 X Yes 2 I if Yas, Give Year or Dates	No WWI	L 1	S Decedent of Pes, specify Cub	dispanto Orlgin? ( an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		- American Indian, k, Whita, atc. White
"natur	Elementery/Sec	15. Decedent's Ed ecify only highest gra condary (0-12)	College (1-4or	5+)			oation during most of wid)	orking	16b. Kind of Bu	siness/Industry
ther than	12 17. Fathar's Nama	(First, Middle, Last)	0	1	Auto Te	echnici		eme (First, Middle,	Auto Maiden Sumami	9)
marked other than marked other than To Be Comp		dney Leake					Maud Wi	, , ,		
sumetic eve		Name/Relationship (			19b. Mailing	Address (Street			er, City or Town,	State, Zip Code) 2153
Item 27 is other trau	Mabel L	eake wi	ife		15614 (	old Con				coning MD
) = <u>+</u>	20a. Method of Dis 1 Burlal 2 4 Donation	sposition  Cremation 3  Other (Specify	Ramoval from State	· cen		on (Name of ony or other pla Cremat		March 11 1999	20c. Location - Cumberla	city or Town, State
Important: If any injury or poce.	James	Funeral Service Licen	Kommi		Eic		McKenzie	Funeral		Α.
esician edical aminer	immediata Cause disease or conditi resulting in death	ion	a. CISQI	rati	S a conseque	nouv	nonio	)		Interval Between Onset and Dea
d by the attending physician and latached for use as the bunal-transit.	Sequentially list of if any, leading to it cause. Enter Unc Ceuse (Disease of that initiated even resulting in deeth)	15	. grter	C   F	rebro	nce of):		ascular		7, mont
ed by the att datached for APhysicia	Part fl. Other sign	ificant conditions co	ontributing to death	but not resulti	ng in the unde	orlying cause gi	ven in Pert I.	23b. Dld	./	tribute to the cause of d
be of								-	2510	V_1100a01) 4_011
should should								24a. Was perfo	an autopsy med?	24b. Were autopsy find available prior to completion of caus of death?
page 2								101	res 2 No	1 ☐ Yes 2 ☐ No
ertific ector Be	25. Was case refe examiner?	erred to medical	Hamital:					eath (Check only o	one)	
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une une	1 Neturel 2 Accident 3 Suicide	5 Pending investigation 6 Could not be	(Month, D	ay Year)	Injury	M 1	ryat rk? ]Yes 2∐No			ed er or Rural Route Number
40 APR -	4 Homicide			tc. (Specify)				City or Tou	vn, State)	
illed in by										nner as steted.
Funeral Direction by filled in by dical Certification	(Check only one)	2 Medical Exam	and manner s	lated.		agation, in my				ind due to the ceuse(s)
To the Funeral Directompletaly filled in by			and manner s	tated.		29c. Licans	sa number		29d. Date signed	(Month, Day, Year)
Pletaly fill	29b. Signature an		urge			29c. Licans	sa number		29d. Date signed	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month MARY AGNES LANTZ 10:40pm lebruary 26, 1999 /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** LIONS MANOR NURSING HOME CUMBERLAND ALLEGANY If Under 24 Hrs. 8. Date of Birth (Month, Dey Year)
DEC 15, 1918 5. Social Security Number 7. Age (In yrs. lest birthdey) if Under 1 Yeer 9. Birthpiece (Stete or Foreign Country)
WEST VIRGINIA **Funeral** Deys 1 ☐ M 2 💢 F 80 Yrs. Director 232-22-2695 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be nothing WV Director MINERAL 1 Yes 2 □ No RIDGELEY 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 10 LYONS STREET 26753 death U.S.A. 11. Maritai Status 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours effer nent of Health end Mentel Hygiene. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 ☑ No Specify: þ Specify: WHITE 3 Nidowed 4 Divorced Be Completed the Medical 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) OWNER?OPERATOR M & M BAKE SHOP 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) is marked COMMADORE STALNAKER 2 **AGNES** (UNKNOWN) traumetic 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 and 2 a Depertment of Health er important: If Item 27 is any injury or other trau RANDOLPH F. LANTZ, JR. / SON P.O. BOX 425 - RIDGELEY, WV 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State SS.PETER & PAUL CEMETERY 3/1/99 4 ☐ Donetlon 5 ☐ Other (Specify) CUMBERLAND, MD 21. Signeture of Funeral Sérvice Licensee 22. Name end Address of Fecility UPCHURCH FUNERAL HOME, P.A. Gerchurce 202 GREENE ST., CUMBERLAND, MD
23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. 21502 Approximate intervel Between Onset and Deeth **Physician** immediate Ceuse (Final disease or condition resulting in death) /Medical monen Examiner Pue to (or es a consequence of): Examiner plewin if or Attending Physician: The law requires that the death certificate be executed effect death.

Director: After this certificate has been signed by the ettending physician and in by the internal director, page 2 should be detecthed for use as the burliet-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown pertension þ Completed 24b. Were autopsy findings evelleble prior to 24e. Was en eutopsy performed? completion of ceuse of deeth? 1 ☐ Yes 2 KNo 1 Tyes 2 No 25. Was cese referred to medicei examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Meaner of Death 1 Natural Certification: 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how Injury occurred Division 5 Pending Investigation 1 Tyes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end manner as steted.

| Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) end manner steted. 29e. Certifier Medicai (Check only one) 29b. Signature end title of cartifler 29c. License number 29d. Date signed (Month, Day, Year) ran 5

Libris Manor Nursing Home, Seton Drive Extended, Cumberland, MD 21502

State Registrar

nes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V.A. Ranjithan, M.D.

MAR 0 5 1990

1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death Month 3 MARY CATHERINE LEWIS lo 4a. Fecility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth SALISBURY PENINSULA REGIONAL MEDICAL CENTER WICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month Days Hours Min. 8. Date of Birth
(Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (Stete or Foreign Country) 1 M 2 F 78 Yrs. 219-05-9286 21, 1920 MARYLAND Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND WICOMICO WILLARDS 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 36007 WOODYARD ROAD 21874 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specity: 3 Widowed 4 □ Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER 8 OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) JOHN R. WARREN MARY **EVANS** E. 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) RALPH W. LEWIS/SON 36007 WOODYARD ROAD, WILLARDS, MARYLAND 21874 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Removel from State 3/10/99 4 ☐ Donetion 5 ☐ Other (Specify) NEW HOPE CEMETERY WILLARDS, MARYLAND neral Service Licensus 22. Name end Address of Fecility HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975 23e. Pert1. Enter the diseese, or compilcations that caused the shock, or heart feilure. List only one cause on each line. muth. Do not enter the mode of dying, such es cerdiac or respiretory errest, Approximete Intervel Between Onset end Death Immediate Cause (Fine) Congestive Heart failure diseese or condition resulting in deeth) nietive Pulmonary Disase Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 2 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Exactions must be notified at

permit. Pages 1 and 2 should be filed within 72 hours eftar to Department of Health and Mental thygiena. Incorant: If Itam 27 is marked other than "natural", or item in mury or other traumatic event, tra Medical Experiment

death

21215-0020

Baltimore, Maryland

Director

Completed by Funeral

Be

buniel-transit the page 2

Examiner should be o certificata After

The law requiras that the death certificate be axecuted P.O. Box 68760, Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Records, by Completed Division of Vital Hospital or Attending Physician: in by the funeral director, Be 25. Was case referred to medical exeminer? 1 Yes 25 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☑ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours efter death. 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Medical 29e. Certifier the Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Madical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. within 24 hou To the Fune completely fi To the of certifier

State Registrar

29b. Signature and

30. Name and address of person who comp cause of death (Item 23e) (Type, Print)

31. Dete filed (Month, De), Year)

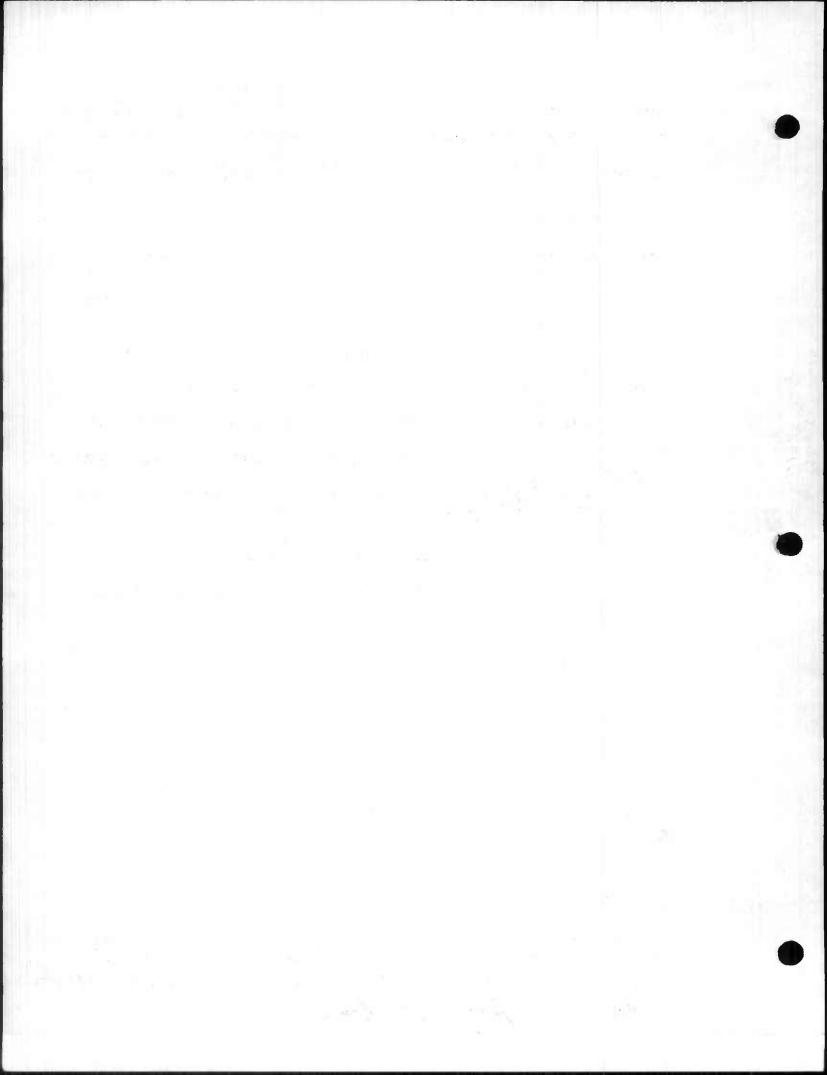
MAR 0 8 1999

32. Registra

29c. License number

29d. Date signed (Month, Dev. Yeer)

Selbyville



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 WCHD/ird Dr. 3/11/99 Certificate of Death Amended Item #2 per 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time of Death 1999 Day 0630 EYMER 4- 1900 LUBOS March 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Snow Hill Nursing & Rehab. Center | Snow Hill | Snow H Worchester Birthpieca (Stata or Foraign Country) 055-10-9118 100 1/20/1899 Pa. Usual Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. insida Clty Limits 1 Yes 2 □ No Wicomico **Bivalve** 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? U • S • A •

14. Race - Amarican Indian,
Black, White, atc. 3563 WINDMILL Road 21814 12. Was Decedant Evar In U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11. Meritel Stetus 1 Nevar Married 2 Merried 1 ☐ Yas 2 No If Yes, Give 1 ☐ Yes 2 No Specify: If Yes, Give Yaar or Datas: Specify: White 3X Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grade completed) 16e. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantery/Secondery (0-12) College (1-4or 5+) 12 Secretary Law Firm 17. Father's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Meiden Sumama) John F. Eymer Lisette Neupert 19a. informent's Name/Raiationship (Type, Print) 19b. Mailing Address (Straet end Number or Rural Routa Number, City or Town, Stata, Zip Code) Kenneth White/ Friend P.O. Box 174, Nanticoke, 21840 Maryland 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata Buriai 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) St Marys Cemetery 3/13 Tyaskin, Md. 21. Signatura of Funarul Servica Licensea MOO=417 22. Nama and Addrass of Fecility Messick Funeral Home, P Bivalve, Maryland 21814 P.O. Box 61 massub 8 23e. Part1. Entar the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cerdiac or respiretory errest shock, or haart failure. List only one cause on aech lina. Approximete intarval Batween Onset end Death PHEUMONIA Immedieta Cause (Finel diseasa or condition rasulting in daath) Dua to (or es a consaquance of): CORONARY ARTERY DISEASE Sequantially list conditions, if eny, laeding to immediata cause. Enter Underlying Causa (Disaase or injury thet initiated avants rasulting in death) Last ADVANCED Dua to (or as a consequence of) Part it. Other significant conditions contributing to death but not rasulting in the undarlying causa givan in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy 2 1 No 1 ☐ Yes 1 □ Yes 2 □ No 28. Place of Deeth (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28a. Data of injury (Month, Day Year) 28c. injury at Work? 28d. Dascribe how injury occurred

**Physician** /Medical Examiner The law requires that the death certificate be executed Box 68760.

**Physician** 

/Medical

**Examiner** 

10a. Stata

Md

Director

Funeral

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Completed

Be

2

Funeral Director

item 27 is marked other than "naturel", or itema 23a or 28a-f ehow other traumatic event, on Medical Examinar must be notified at

permit. Peges 1 and 2 should be filed within 7. Department of Health and Mentel Hyglene. Important: If item 27 is marked other than "ne any injury or other traumatic event, me Medic page.

filed within 7 if Hyglene.

72 hours efter death with the Marylend

Baltimore, Maryland 21215-0020

ettending physician and for use es the buriel-transit signed by the e peed page 2 s certificate director this After this funeral

Division of Vital Records, P.O.

or Attending Physician:

the Hospital

0

death.

Physician/Medical Examine by Completed Be 2 Certification: in 24 hours enter the Funeral Director: A

Medical

completely within 2 To the 10 20 State 25. Was casa rafarred to medical axaminar? 1 Yes 2 No 27. Menner of Death 5 Panding Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homlcide 29a. Certiflar (Check only one) 1 Certifying Physician: To tha best of my knowledga, daath occurred at the time, data and place, and dua to the causa(s) end mannar as stated.
2 Medical Examinar: On the bests of axamination end/or invastigation, in my opinion, daath occurred at tha time, dete and pleca, end due to the cause(s) and mannar stated. 29b. Signature end titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 150759 FOCASTIADE 30. Nema and addrass of person (no completed ceusa of daath (itam 23a) (Type, Print) CHARCES FOC 540 RIVERS DE DR SUTTE 5 SALISBURY

31. Date filed (Month, Day, Year)

MAR 1 0 1999

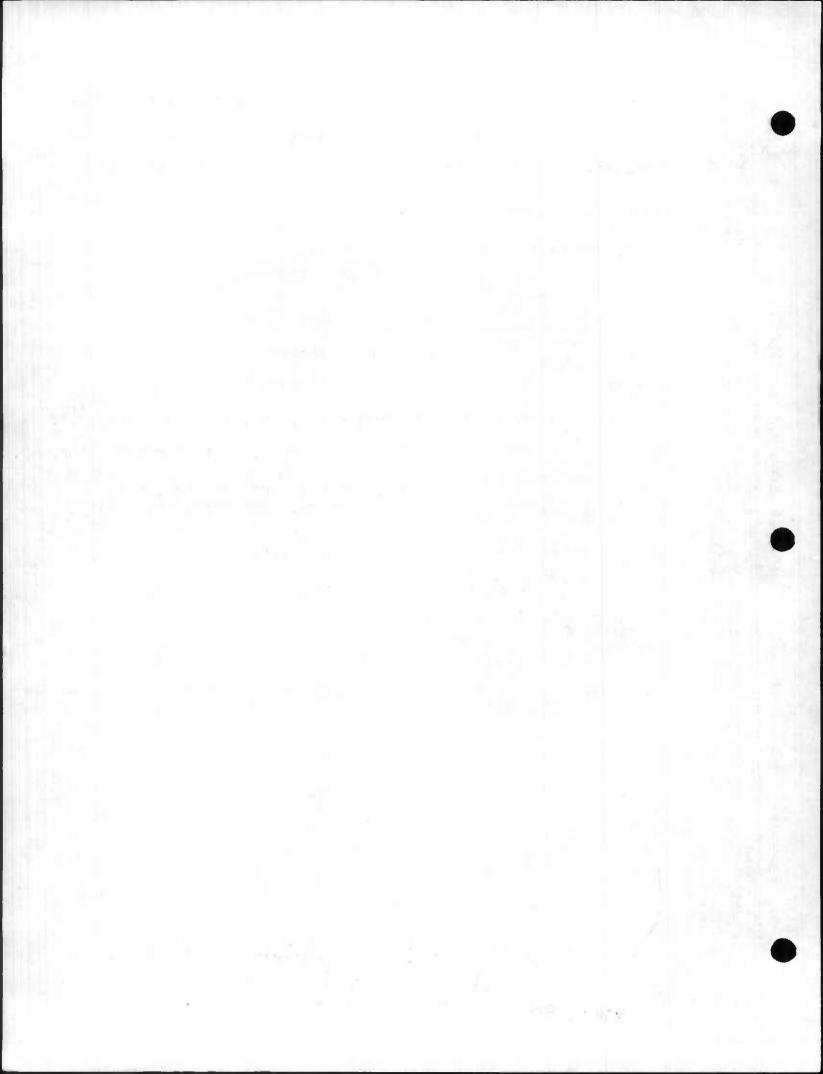
32. Ragistrer's Signature

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 226

			Cei	rtificate of	Death	8	leg. No.	w has two
Dhusisian	1. Decedent's Name (First, Middle, Last	)				2. Dete of Dea		3. Time of Death
Physician /Medical	GLADYS LARKIN	IS				MARCH	6 <sup>D</sup> 1 999 Ye	20:14
Examiner	4a Facility Name (If not institution, give ANNE ARUNDEL ME		ER		ANNAPOI		4c. County of C	RUNDEL
Funeral Director	5. Social Security Number 6. Sa 246-32-6836 1D Usual Rasidence of Decedent	x 7. Age (In yrs. 73	last birthday) Yrs.	If Under 1 Yea Months Days		2 1925 I	Birthplace (State or Foreign Country) MARYLAND	
ithe Maryland rates show notified at rector	10a. State 10b. County MARYLAND ANNE AF		y, Town or Lo				10d. Inside City Limits 1 ☑ Wes 2 ☐ No	
D 20 0	1916 B. COPELAN	D STREET		10f. Zip Code 214		1	0g. Citizen of What	Country?
0020 ours after death ref., or ferme 23 Examiner must	11, Marital Status  1 □ Never Married 2 □ Married  ③□ Widowed 4 □ Divorced	12. Was Decedent Evar in U, Armed Forces? 1 ☐ Yes 為 No If Yes, Give Year or Detes:		Was Decedent of If Yas, specify Cu 1 ☐ Yes 2 ☑ No		(Specify Yes or No- arto Rican, etc.)	Bleck, V	Vinerican Indian, Vinite, etc. BLACK
72 ho	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occi	e during most of w	orking	16b. Kind of Busine	ess/Industry
1 21215-0020 led within 72 hours at bygene. her than "natural", or nt, the Medical Exam Completed by I	Elementery/Secondary (0-12) 12th 17. Father's Name (First, Middla, Last)	College (1-4or 5+)	life. I	DO NOT use retir	PROVIDE	ER .	SELF EMI	PLOYED
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Maryland 42 should be file 5 should be file 6 and Mental Hy 7 is marked oth Traumatic event To Be (	WILLIE WILL]  19a. Informent's Name/Relationship (T)		19h Mailir	no Address (Stree		G JENKIN Rural Route Number		te Zin Codel
4 2 2 2 2	MELVINE BROWN (I	AUGHTER)	215 (	COZINE	AVE. AF		BROOKL	11/.0//
altimore mit. Pages 1 partment of He portant: if then y Injury or oth	20a. Method of Disposition  1  Surial 2  Cramation 3  4  Donation 5  Other (Specify)	emoval from Stete MAF	leca of Dispo emetery, crer YLANI	esition (Name of metory or other pl VETER	AN CEME		20c. Location - City 99 CROWI	or Town, State NSVILLE, MD
Ball permit Depart import any inj ansa	21. Signature of Funeral Service Licens  23a. Part 1. Enter the disease, or cornel		W		E & SON	IS MORTU		A .
Wedfcate be executed ing physician and eas the burial-fransit Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	Hapert	r as a consequence of as a consequence of the sequence of the	quenca of):	rescul st	lu /ti	Rhy75	2 day
		+ recort						
Phy the detach	Pert II. Other signiticant conditions cor	tributing to death but not resu	ulting in the u	nderlying cause g	iven in Pert I.			oute to the cause of death? Probably 4 Unknown
aw requir						24a. Was e		tb. Were eutopsy tindings evailable prior to completion of cause of death?
Co Cate						1/S Y	es 2 No	1 ☐ Yes 2 No
Physician: The Introduced the This certificate hural director, page 11: To Be Com	25. Was case referred to medical examiner?	lospital:	ED/C +- "	4 25 20 10	thor	eath (Check only or		0
ding Physic After this of funeral dire	1 Yes 2 No  27. Menner of Death 1 Netural 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj	4 LI Nursing	Home 5 ☐ Reside	enca 6 LIOther (S	Specify)
DIVISION OF  To the Hospital or Attending Phy within 24 hours after death.  Co the Funeral Director, Aller thi completely filled in by the funeral  Medical Certification: 7	3 Suicida 6 Could not be determined	28e. Plece of Injury - At ho building, etc. (Specify		eet, factory, office	•	28f. Location (S. City or Town		Rural Route Number,
To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	ician: To the best of my knowner: On the basis of examinet and manner steted.	wiedge, deeth ion end/or inv	occurred et the vestigation, in my	time, date end pla opinion, death oc	ce, end due to the courred et the time, d	ause(s) and manne late end placa, end	r es stated. due to the cause(s)
To the within To the comple	296. Signature and Affe of certifier	ulace,	end	29c. Licer	D4121	2	3/7/9°	lonth, Day, Year)
	30. Name end address of person who co	mpleted cause of death (Item	23a) (Type,	Print) WRS	+ 24.	Ahn a	lis. N	ld
State	31. Data filed (Month, Dey, Year)	32. Registrar's Signa	ture 6.	Sport	de la			-



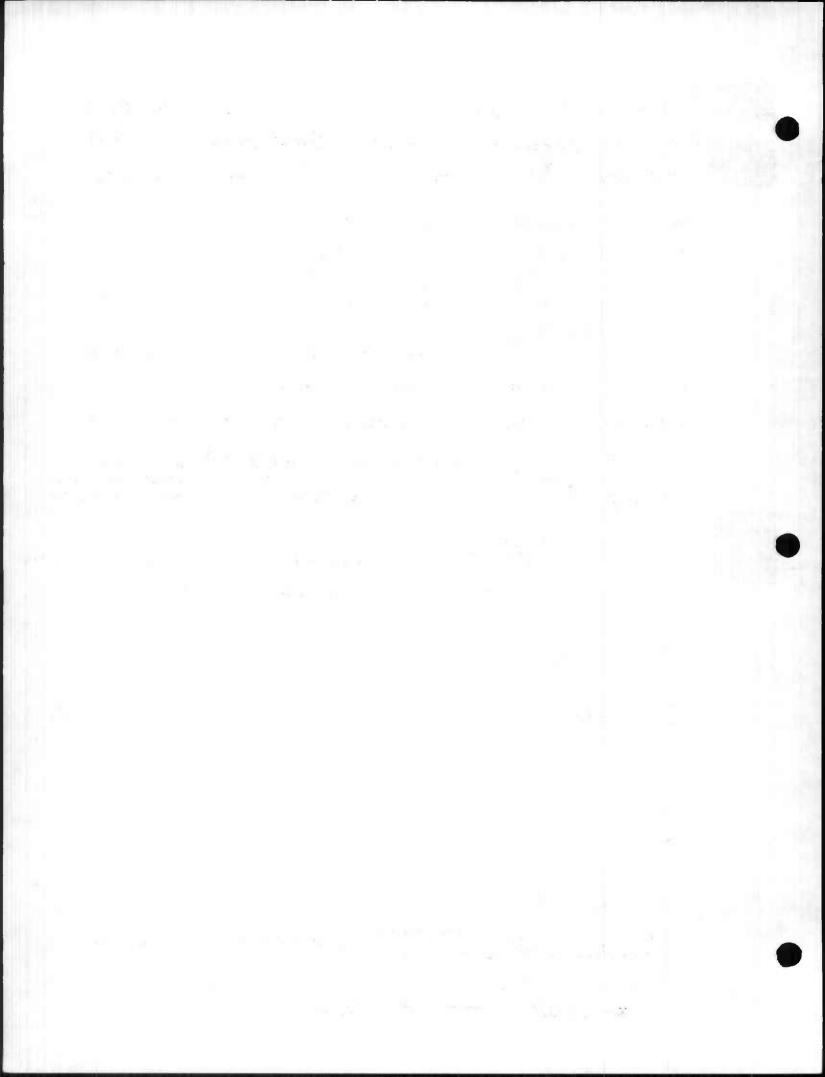
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State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 2322 oh AASMAR 050 /Medical 4b. City, Town, or Location of Deeth 4e. Fecllity Neme of not institution, give street end number) Examiner orth OSPITAL Burrie Clev runde 6. Sex № 1 M 2 F If Under 1 Yeer If Under 24 Hrs. Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Director 301-36-1306 56 AUG. 4, 1942 OHIO Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f sho traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 814 GLENVIEW AVENUE 21061 II.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 凶 Yes 2 □ No 196 If Yes, Give Year or Dates: 1966 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Rece - American Indian, Black, White, etc. filed within 72 hours after c Hygiene. ther then "netural", or fter 1962-1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√ No Specify: þ Specify: WHITE 3 Widowed 4 Divorced 1966 Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) PRESIDENT OF CEO HEALTH CARE permit. Peges 1 and 2 should be file Depertment of Health and Mental Hy Important: if item 27 is marked other any Injury or other traumatic event. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) ELIAS MANSOUR LaASMAR SELMA MOSES 19a. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) EVELYN LaASMAR (WIFE) 814 GLENVIEW AVENUE, GLEN BURNIE, MD. 21061 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete CHESAPEAKE CREMATION CENTER LLC 4 Donetion 5 Other (Specify) CHESTER, MD. 22. Name end Address of Fecility SINGLETON FUNERAL HOME, P.A. 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Onset end Deeth **Physician** /Medical Infarction Immediete Cause (Final Myocardial diseese or condition resulting in deeth) Examiner Heart teriosclerotic siclan and buriel-transit Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting In deeth) Last physician s the buriel P.O. Box 68760. Physician/Medical Due to (or es e consequence of): 93 etten Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? hed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1Abetes Records, ò 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? hes 1 □ Yes 2 □ No certificete Division of Vital To the Hospital or Attanding Physician: within 24 hours efter death.

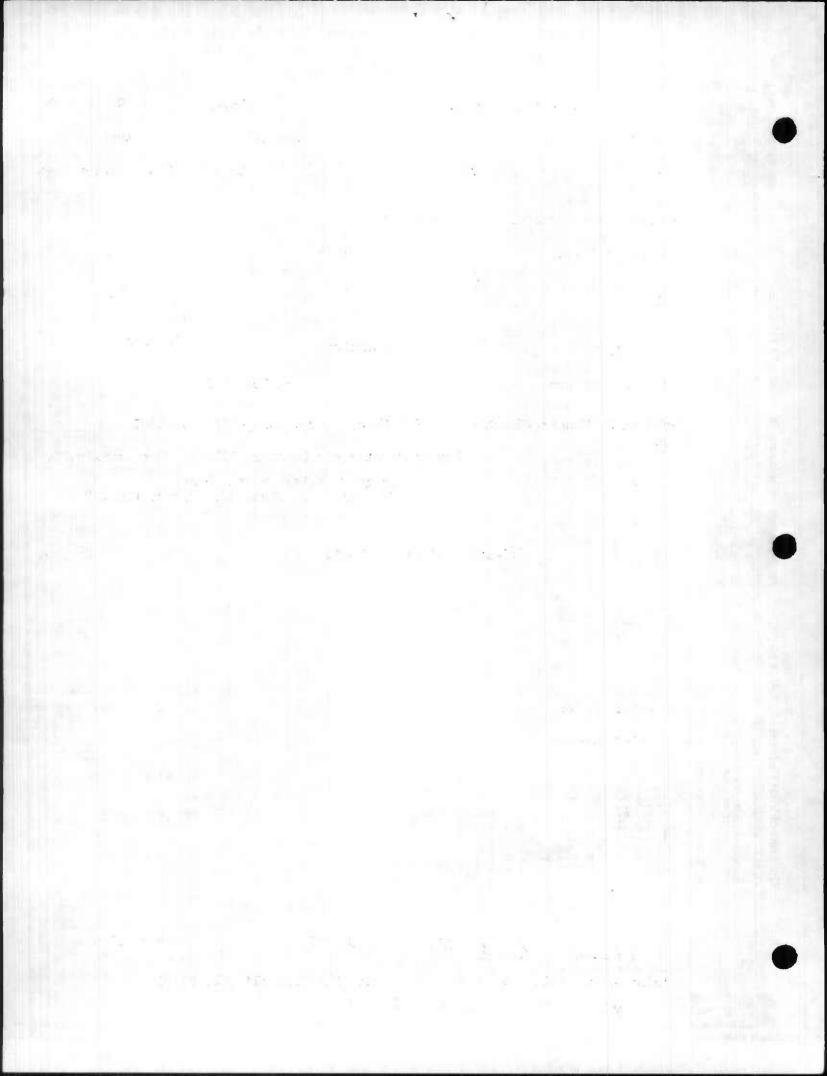
To the Funeral Director: After this certification completely filled in by the funeral director, 25. Wes cese referred to medical 26. Place of Deeth (Check only one) exeminer 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 R/Outpetient 3 DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Neturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Hedical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner stated. Medical 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Deputy nd address of person who completed cause of deeth (Item 23e) (Type, Print) America ones, mo 32. Fegistrer's Signature State Registrar

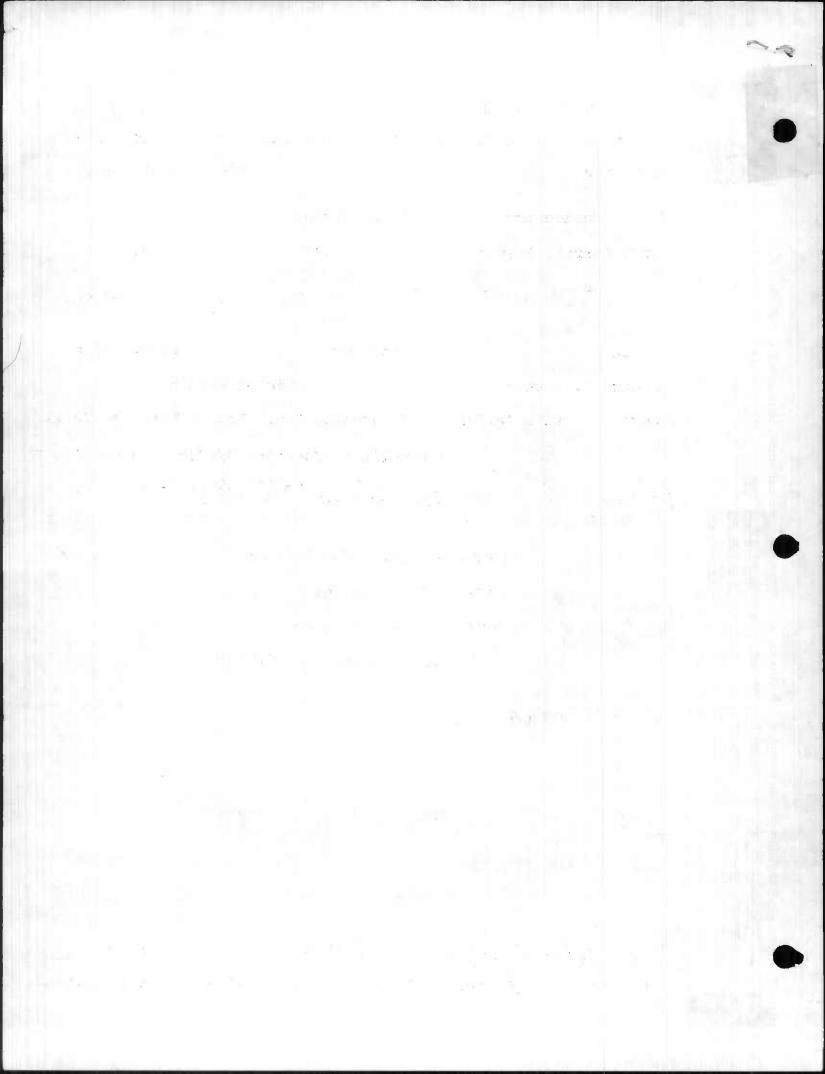


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	Physician	Decedent's Nama (First, Middle, L		D				2. Date of De		999°	3. Tima of Death
	/Medical		Agnes La	Kose			4b. City, Town, or	March			6:06AM
À	Examiner	4a Facility Name (If not institution, gr 950 Marconi Ave					Annapo	lis	Anne	Aruno	de1
	Funeral Director	055-07-7948		a (In yrs. lest i		Inder 1 Year onths Days	If Under 24 Hrs Hours Min.		4,1920	9. Birthple Count Clini	ace (Stata or Foreign (Y) Con, Iowa
	pue *	Usuel Residence of Decedent  10a. State  10b. County		10c. City. To	own or Location	n				10	Od. Insida City Limits
	Manyle of sho	Maryland Anne An	undel	Annapolis							1 ☐ Yes 🛪 🗓 No
	fler death with the Mai r flerms 23a or 28a4 s from maint be molified Funeral Director	10e. Street and Number 950 Marconi Ave				of. Zip Coda 2140	1	10g. Citizan of What Count USA			ry?
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21215-0020	e filed within 72 hours earl Hygiene. other than "naturel", ovent, the Moderal Eve	15. Decedent's E (Specify only highest g. Eiementery/Secondary (0-12)		16	6a. Decedant's (Give kind of lifa. DO N Home	Usual Occup of work dona OT usa retire emaker	oation during most of world)	rking	16b. Kind of B		ustry
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lan	id be fill he out ked out ic ever	John J. Watters	3				Isabe	el Smit	h		
Maryland	should be and Mente and Mente or numeric or	19a. informant's Name/Ralationship	(Type, Print)	1:	9b. Mailing Ad	drass (Straat	and Number or Ri	urel Route Numb	ar, City or Town	Steta, Zip	Code)
M.	end 2 salth a salth a r 27 la	Kathleen M. Manni	ng/Daughte				Ave. Anna	apolis,M	D. 2140	1	
Baltimore,	permit. Pages 1 end 2 should Department of Health and Men Important: If Item 27 is marke any Injury or other traumatic once.	20e. Method of Disposition  12 Burial 2 Cramation 3 4 Donation 5 Othar (Spec		cema	of Disposition tary, cramatory and Vet	y or othar pla	ce) s Cemete	Data ry 3/10/	20c. Location		
Balt		GEONAM And Address of Facility Funeral Home 2973 Solomons Island Rd. Edgewater, MD. 234 Pirtl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pock, or heart failure. List only one cayse on each line.									21037
		234 Phrt1. Entar tha disaasa, or cor	nolications that causad ona cause on aach lie	tha daath. D	o not anter the	mode of dyi	ng, such as cardia	c or raspiratory a	rrast,		Approximate Intarval Batween
	Physician /Medical Examiner	Immediate Cause (Final disease or condition rasulting in death)  Primary biliary Cirrhosis  Dua to (or as a consequence of):									Onsat and Death $2\frac{1}{2}$ yrs.
	STEEL WAS										
,	ficate be executed physician and is the burial-transit edical Examiner	Sequantially list conditions, if any, laading to immediate cause. Entar Underlying Cause (Diseasa or injury that initiated evants	b	Dua to (or as	a consequenc	e of):				I I	
κ 68760,	- 0 0	Cause (Disaasa or injury that initiated evants rasulting in daath) Last	cDua to (or as a consaquanca of):								
Box	death cer e attendir ed for use		d								
P.0.	at the death cert d by the attendin etached for use Physician/W	Part II. Other significant conditions hypertension	contributing to death be	ntributing to death but not resulting in the underlying cause					tobacco usa co		the causs of death?
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E E	sicien: The law certificate has tirector, page 2 s							10	Yas 2 🗓 No	10	Yas 2□ No
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Divi	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (	4 Homicida datamine	building, at	: (Specify)				City or To	Streat and Num wn, State)		
	To the Hospital within 24 hours of To the Funeral I completely filled	29a. Certifier (Check only one)  (Check only one)	hysician: To the best of minar: On the basis of and manner sta	axamination	lge, death occu and/or Invastig	urred at the tigation, in my o	me, date end place opinion, daeth occ	e, end due to the urred at the tima,	cause(s) end m date and piece,	anner as sta and due to	ated. tha ceusa(s)
	vithin of the comple	29b. Signetura and titia of cartifiar	and maintai 500			29c. Licens			29d. Data signe	ed (Month, L	Day, Year)
	->-0	* Claure	anata	10	/	D452	97		March 8	, 1999	)
	6.6 ()	30. Neme and eddress of person who Elaine Arata, M.	D. 104 Rid	gely A			1 Annapol	lis,MD.	21401		
	State Registrar	31. Data filed (Month, Day, Year) MAR 0 9 1	999 32. Registra	ar's Signature	<i>b</i> .	Some	41				

Registrar



	1. Decedent's Name (First, Middle, Last)		Certificate of		2. Dete of De	Reg. No.	3. Time of Deeth
Physician		MARTIN, SR.			MARCI	Dey 4 02 /	Yeer 999 10:28 A
/Medical Examiner	4a Facility Neme (If not institution, give str			4b. City, Town, or L			
Lammer	Washington Adve		oital	Takoma	Park	MON	rgomery
Funeral Director	5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. In 68	Yrs. If Under 1 Ye Months De		8. Date of Bir (Month, De Jan. 4	th (Year) 1931	9. Birthplece (State or Foreign Country) Maryland
2 >	Usual Residence of Decedent  10e. State 10b. County	10c City	Town or Location				10d. Inside City Limits
28a-f show	MD Montgome		Silver Sp	ring			1 Tyes 2 XNo
r tems 23a or 23a-f el internant be retified Funeral Director	10e. Street and Number 8602 Carroll	Avenue	10f. Zip Cod	0903		10g. Citizen of V	
b	11. Meritel Stetus 12  1 Never Married 2 Merried 3 Widowed 4 Divorced	. Wes Decedent Ever In U,\$ Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes:	13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Specify:  No Specify:	pecify Yes or No Rican, etc.)		a - American Indien, sk, White, etc.
and Hygiene "natural dother than "natural vent, I've Med Call Be Completed	15. Decedent's Educa (Specify only highest grade of	tion completed)	16e. Decedent's Usuel Oc (Give kind of work do iife. DO NOT use re	cupetion ne during most of work	ding	16b. Kind of Bu	usiness/Industry
than than	Elementery/Secondery (0-12) 6th	College (1-4or 5+)	Laborer			Const	ruction
Hygiene. ent, the v	17. Fether's Neme (First, Middle, Last)			18. Mother's Nam	e (First, Middle		
end Mental Hygiene. s marked other than humstic event, the M. To Be Comp	Howard C. Mar	tin		Viole	et Mar	tin	
9 w w	19a. Informent's Name/Reletionship (Type Gladys B. Martin		19b. Meiling Address (Str. 676 Houst				State, Zip Code) , MD 20912
nt: If item 27	20a. Method of Disposition  1 Buriel 2 Cremetion 3 Rer  4 Donetion 5 Other (Specify)	Ce Ce	eca of Disposition (Name of metery, crematory or other cropolitan	place)	Dete = 3/6/		City or Town, Stete
Department of Important: If I any injury or one	21. Signature of Funeral Service Licenses	herus	0.4.	dress of Fecility N FUNERA			
	23a. Part1. Enter the disease, or complice shock, or heart falluline. List only one	form thet caused the deeth		LLE, MD dylng, such es cardiac	20850 or respiretory		Approximete
nysician	shock, or heart fallere. List only one	seume on each line.					Interval Between Onset end Death
Medical kaminer	Immediate Cause (Final disease or condition	MOMITIN	6 AND AS	PIRATION	V		1 HR
	resulting in deeth) e		es e consequence of):				
nine	b		5 MELLIT	VS			
al-trar	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury		es e consequence of):				
physician and s the burial-transit adical Examiner	thet initieted events	REMAL	NSVFF1C es e consequence of):	IENCY			
ding phy se es the	resulting In deeth) Lest	COROM	,	ERY DIS	EASG		
d for use ending	Pert II. Other significant conditions contri			given in Pert I.	23b. Did	tobacco use co	ntribute to the cause of death?
ed by the deteched	HYPERTENSI	^	d			Yes 2 No	3 Probably 4 Unknow
within 24 hours effer deeth.  To the Funeral Director: After this certificate hes been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir					24a. Wes	en autopsy ormed?	24b. Were eutopsy findings evaileble prior to completion of cause of death?
page 2					10	Yes 2 No	1   Yes 2   No
certificate rector, pag	25. Wes case referred to medicel exeminer?	2.1		26. Place of Dee	th (Check only	one)	
this ce rel dire	1 Yes ZENo	/)	Produpetient 3 DOA			idence 8 Oth	
within 24 hours effer deeth. To the Funeral Director. Affert completely filled in by the funer. Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be	(Month, Dey Year)		njury et Work? I ☐ Yes 2 ☐ No		how injury occur	per or Rural Route Number,
urs efter ral Dire	4 Homicide determined	building, etc. (Specify			City or To	wn, State)	
n 24 ho he Fune pletely fi	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	lan: To the best of my known: On the basis of examinetiend manner steted.	rledge, deeth occurred et the on end/or investigation, in m	e time, date end plece, ny opinion, deeth occur	, and due to the rred et the time,	ceuse(s) end ma , dete end pleca,	anner es steted. end due to the ceuse(s)
To the comp	29b. Signature and title of certifler			ense number			d (Month, Day, Year)
	1 / Allur	ant 1	D-1	9400		3-3-	-99
	30. Neme and eddress of person who com	pleted cause of deeth (Item	23e) (Type, Print)				VER SPRING
	ERNESTO A	FRICANO	M.D. S	31 UNIVER	SITY B	LVD- 516	VER SPRING
State Registrar	31. Date filed (Month, Dey, Year) MAR 0 9 1999	32. Registrer's Signal	G. Spar				



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Mar. 5:50 AM Edward Moaney /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Easton Hospice Foundation 8. Date of Birth (Month, Day, Year) April 2,1926 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthpiaca (Stete or Foreign **Funeral** Min. Days Hours 180 M 20 F Months Maryland Director 213-22-6399 72 Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Talbot Easton Maryland 10f. Zip Code 10g. Cifizen of What Country? 10e. Street and Number 9 USA 21601 "natural", or items 23a 10180 Copperville death Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever In U.S. Armed Forcas? 14. Raca - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural". A sary injury or other traumatic averages. Black, White, etc. 1 Yes 2 □ No If Yes, Giva 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify. by If Yes, Giva Year or Dates: 1945 -1947 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Private Family Estate Caretaker 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middle, Last) Be Drake Mary Ethel Moaney, Sr. W. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10180 copperville Rd., Easton, Maryland 21601 Kevin Moaney (son) 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/10/99 Easton, Maryland Copperville Cemetery 22. Name and Address of Facility
Bennie Smith Funeral neral Service Licer P.O.Box 1687, Easton, Maryland 21601 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failura. List only one ceuse on each line. Approximete Intarval Between Onsat and Death **Physician** more than /Medical tmmediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequer Examiner attending physician and for use as the burlel-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? á 2 No 3 Probably 4 Unknown signed b Division of Vital Records. þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? The law page 2 2/2/No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 曹 28d. Describe how injury occurred 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Hospital or Attending P
 24 hours after death.
 Funeral Director: After t Affar Netural 5 Pending 1 Yes 2 No 2 Accident Invastigetion 6 Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral 5 10 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and mannar stated.

State Registrar

Medical

29a. Certifier

29b. Signature and liftle of certified

AWEINCE

e and address of person who completed cause of death (Item 23a) (Type, Print)

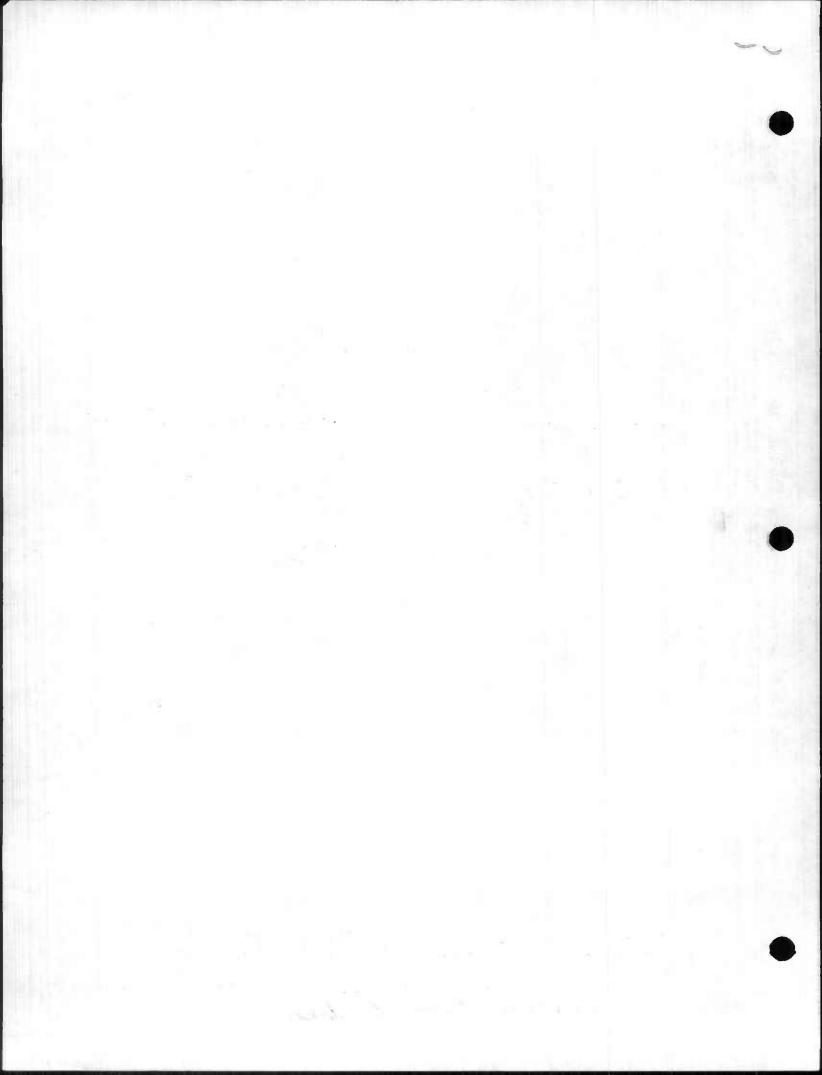
Registrar's Signature

fo the

29c. License number

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month 28 10:25 PM Mary C. Murray 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 6. Data of Birth (Month, Day, Year) April 21, 1917 5. Social Security Number Birthplaca (Stata or Foreign Country)
 Ohio 7. Age (In yrs. last birthday) Days Months Hours 1 M 2 XF Yrs 407-09-3728 Usual Residence of Decedent 10s. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9233 East Parkhill Drive 20814 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Merital Status Black, Whita, atc 1 Yas 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Specify: Specify. 3 ☐ Widowed 4 ② Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) American Red Cross Fiscal Officer 12 18. Mother's Nama (First, Middla, Maidan Sumame) 17. Father's Nama (First, Middle, Last) Mary Elizabeth Degnan Louis Dowling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Truda Eugenie D'Andelet/Cousin 9233 East Parkhill Dr., Bethesda, MD 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) Data 20c. Location - City or Town, Stata 1 2 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery | 3/4/99 Silver Spring, MD 22. Nema end Addrass of Fecility Francis J. Collins Funeral 21. Signature of Funeral Service Licens Home, Inc. 500 Univeristy Blvd., West Silver Spring, MD 20901 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediate Causa (Final disease or condition resulting in death) Ventricular Tachycardia
Due to (or as a consequence of): te Myocardial Infarction
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Ischemic Cardiom vopatty Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death?

Examine that the death certificate be executed physician and the burial-transit Box 68760 Physician/Medical 987 Division of Vital Records, P.O. ģ Completed To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this cardillor completely filled in by the funeral director; Be Certification: To

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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**Funeral** 

Director

7 is marked other than "natural", or itsme 23s or 28s-f shov traumetic event, the Medical Exeminer must be notified at

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if Nem 27 is marked other any injury or other traumatic event.

**Physician** 

Examiner

/Medical

the Maryla

Baltimore, Maryland 21215-0020

Einphay sen	ha			1 Yaa 2 No	3 Probably 4 Unknown	
			er 1.33	24a. Was an autopsy performed?	24b. Wara autopsy tindings available prior to completion of cause of death?	
				1□ Yas 2 10 No	1 □ Yas 2 ₩ 100	
25. Was case referred to medical		eath (Check only ona)				
examiner? 1 Yas 202 No	Hospital: 1 Inpatient 2	ER/Outpatient 3□	Homa 5 ☐ Rasidence 6 ☐ Ott	ner (Specify)		
27. Manner of Death 1 SH atural 5 Pending 2 Accident investigation		28b. Tima of Injury	28c. Injury at Work? 1 Yaa 2 No	28d. Dascribe how injury occur	rred	
3 Suicide 6 Could not be detarmined	28a. Place of Injury - At h building, etc. (Speci	oma, farm, street, factiv)	tory, office	28f. Location (Street and Numi City or Town, Stata)	ber or Rural Route Number,	
				ce, and dua to tha cause(s) and mo curred at tha tima, data and place,		

State Registrar

edical

29b. Signature and titla of certifier

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

an -MD.

TET WEI CHAN 8600 Old Georgetown

31. Data filed (Month, Day, Year) MAR 0 8

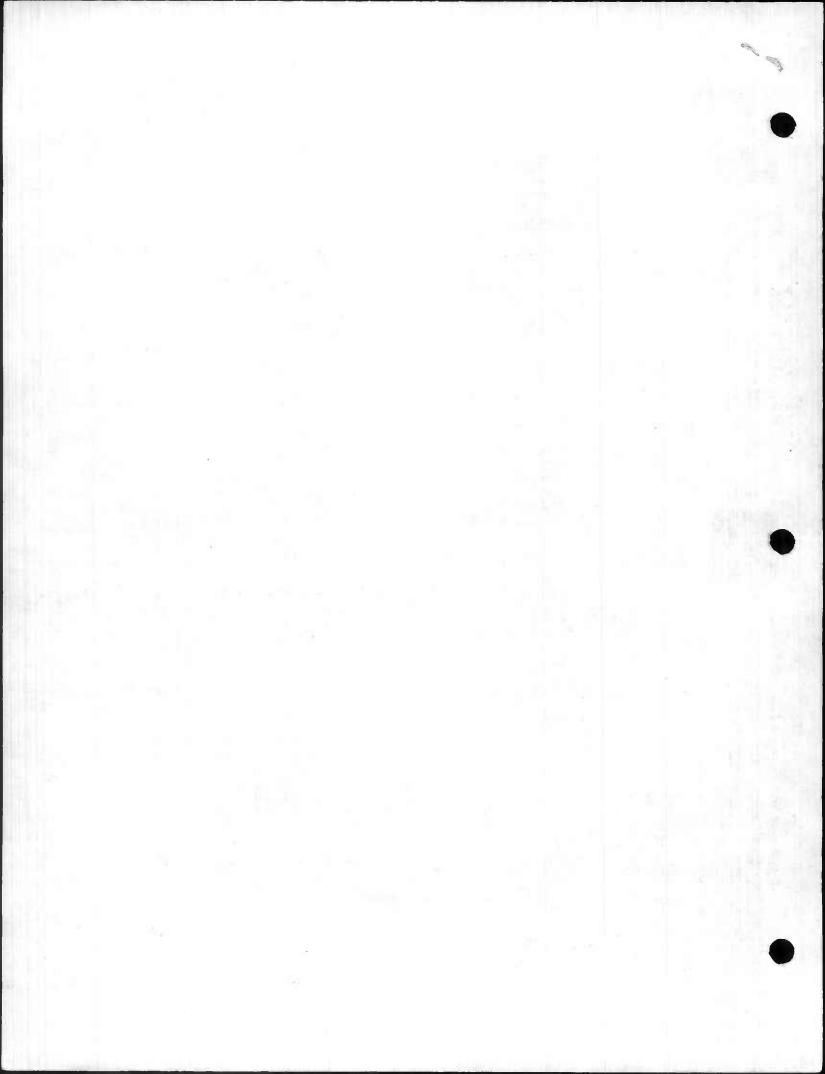
32. Registrer'a Signature

29c. Licensa number

0050748

Bethesda, MD 20814

29d. Data signed (Month, Day, Year)



physician and the burial-transit 9Sm P.O. Division of Vital Records, has death. or Attend after death Director: Hospital 24 hours a Funeral D

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

**Funeral** 

**Director** 

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at

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2 should be filed within 72 hours after n and Mental Hygiene. Is merked other than "natural", or ite

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum pance.

Physician

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Physician/Medical

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Certification:

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Baltimore, Maryland 21215-0020

the Maryland

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical exeminer? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of tnjury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. (Check only one) 2 Medical Exeminer: On the basis of exeminetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TC Shesadni, State

31. Date filed (Month, Dey, Year)

29b. Signature and title of certifier

Obstracy

MAR 09 1999 32. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TC Shesadmi, 3060 mitchellville Rd, #103

29c. License number

D 53411

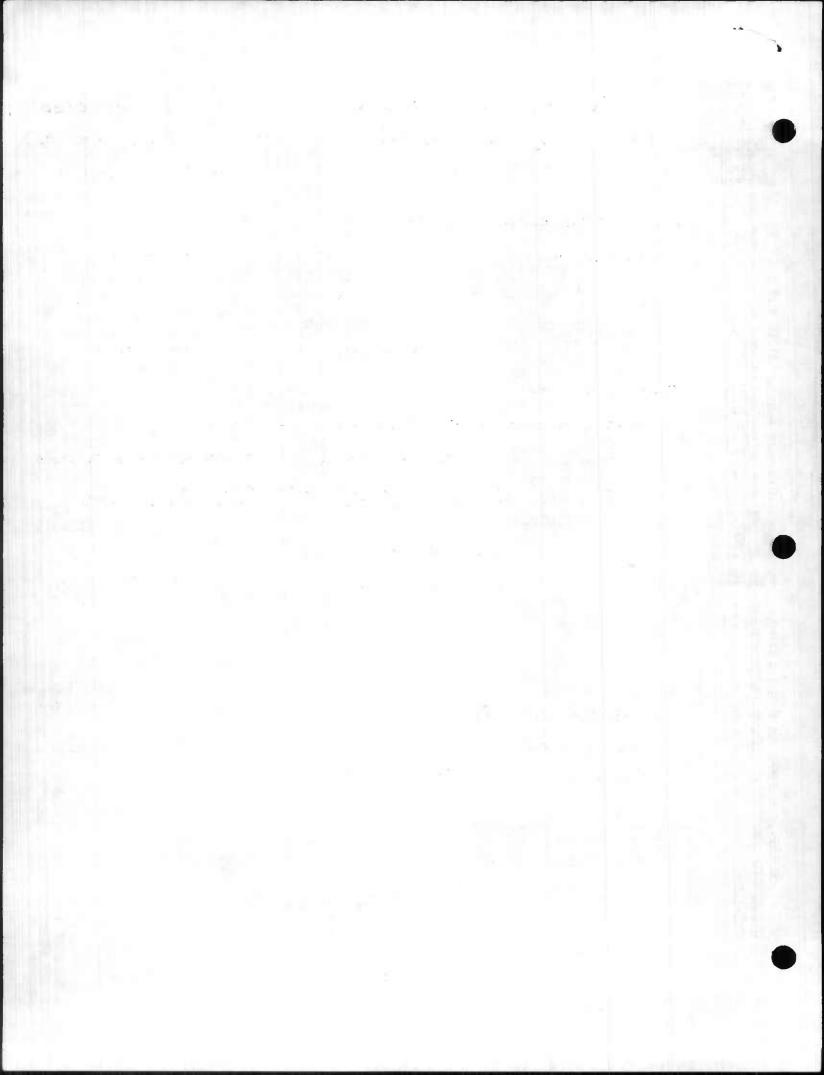
BOWIE,

29d. Date signed (Month, Day, Year)

March, 01, 99

Registrar

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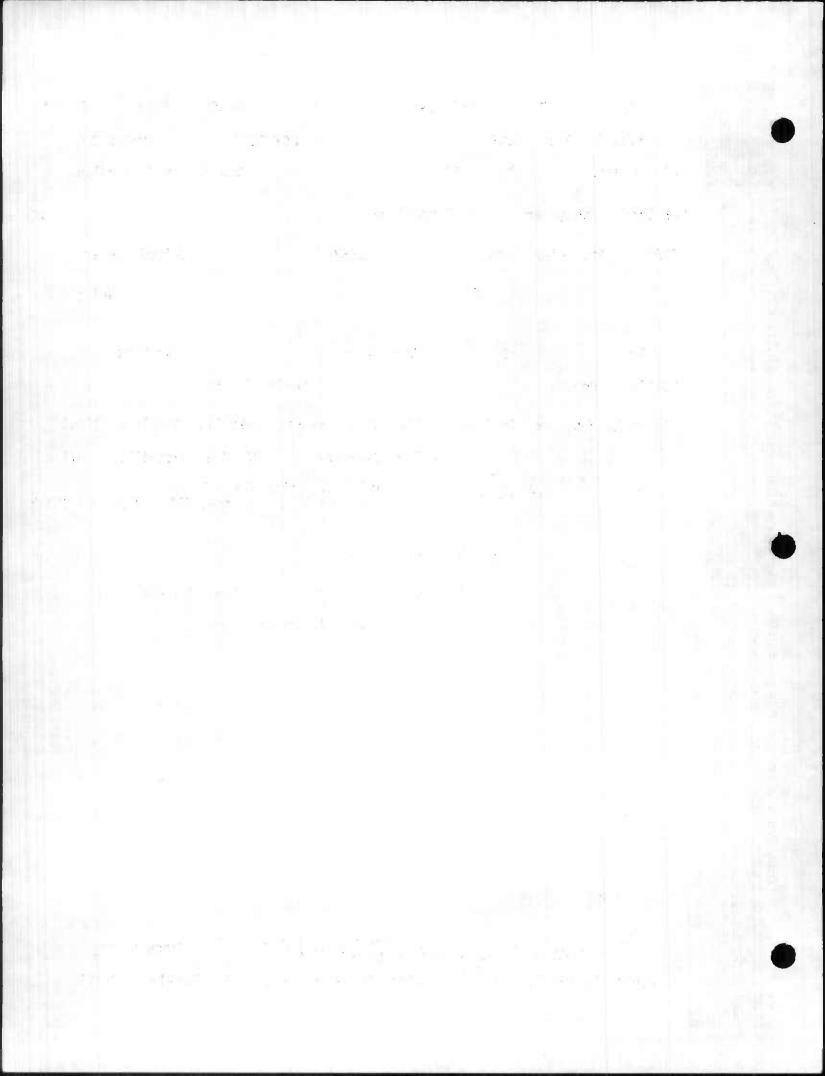


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State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** HA7FI MUSGROVE MARCH 8 1999 6:00 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ROCKVILLE NURSING HOME ROCKVILLE MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Dec. 7 19 7. Age (In vrs. last birthdey) Birthpiece (Stete or Foreign Country) **Funeral** 1 □ M 25 F Monfhs Deys Hours 76 Yrs. 218-14-4907 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland neat of health and Mental Hyglane. And the firm 27 is marked other than "paturel", or items 23s or 23s-f show any or other traumatic event, the Medical Exprises maint to notified at any or other traumatic event, the Medical Exprises maint to notified at 10e Stefe 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Montgomery Germantown 1 ☐ Yes 2 PNo Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20874 12201-C St. Peter Court United States Funeral 14. Raca - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 25No If Yes, Give Year or Dates: 11. Marifal Sfetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No White Specify: Specify: p 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18 Mother's Name (First Middle Melden Sumeme) 17. Father's Name (First, Middle, Last) Be Willie Mc Ga ha Annie Ε. Ray 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas W. Musgrove, Sr./Son 1107 Scott Avenue, Rockville, Maryland 20851 20b. Plece of Disposition (Name of cemetery, cremetory or other placa) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 □ Cremation 3 □ Removel from Stete permit. Page Depertment of Important: If any injury or Parklawn Cemetery 3/10/99 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
Muriel H. Barber Funeral Home 21. Signeture of Funeral Service Licenses u P. O. Box 5038, Laytonsville, Maryland 20882 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset end Deeth **Physician** /Medical Immediate Cause (Final emos disease or condition resulting in death) Examiner Examiner physicien end s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): attending pl signed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ law requires 24b. Were autopsy findings available prior to completion of cause of death? been s 24e. Was en eutopsy Completed pege 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice director, 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) To Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) No No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28e. Date of Injury (Month, Day Yeer) 28c. Injury et Work? Naturel 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funeral D completely filled i 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. License number MARCH 8, 1999 20 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Westphal, M.D. 809 Veirs Mill Road, Rockville, Maryland Frauke 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State MAR 0 9 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3 Time of Deeth Day 1999 Month Bernadette C. Mann March 6, 4:15pm 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Holy Cross Hospital Silver Spring Montgomery If Under 1 Yeer If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthdey) 5. Sociel Security Number Birthplace (Steta or Foreign Country) 1 M 2 F Yrs 217-74-0818 Feb. 11, 1908 Wisconsin Usual Residence of Decedant 10c. City, Town or Location 10d. Insida City Limits 10a, State Montgomery Silver Spring 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1401 Peacefull Lane 20904 USA 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Spacify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 Yas 2 No If Yas, Give Yaar or Dates: 1 Never Merried 2 Merried White 1 Yas 2X No Specify: 38 Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast greda complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Home Maker Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Edward Perrizo Mary Melvina Marcoe 19a. Informant's Neme/Ralationship (Typa, Print) 19b. Meiling Addrass (Straat and Number or Rurel Route Number, City or Town, Stata, Zip Code) 1545 15th Ave. S.E. #12 St. Cloud, MN 56304 Sylvia A. Gowan (Daughter) 20b. Place of Disposition (Nama of cematary, cramatory or other plece) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1 ☐ Burial 2 € Cramation 3 ☐ Ramoval from State 3-11-99 Brentwood, MD Mancoln Crematory 4 Donation 5 Other (Specify) 21. Signature of Funaral Sarvice Licensea 22. Nama and Addrass of Facility Hines-Rinaldi 11800 New Hampshire Avenue Silver Spring, MD 20904 Part I. Entar tha disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) Abdominal Aortic Aneurysm 5years Dua to (or as a consequanca of): Arteriosclerotic Cardiovascular Disease 15 years Sequentially list conditions, if any, laading to immediata ceusa. Entar Undarfying Ceusa (Diseasa or Injury that Initiated avants rasulting In death) Lest Due to (or es a consequence of): Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Urinary Tract Infection 24b. Ware autopsy findings available prior to 24a. Was an autopsy completion of ceuse of death? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cesa referred to medical axaminar? 28. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yes 2 No Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Menner of Deeth 28d. Dascriba how Injury occurred 28b. Tima of 28c. Injury at Work? 1 Netural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datamined 3 ☐ Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida

physician end the burial-trensit the death certificate be executed Division of Vital Records, P.O. Box 68760, 89 use ed by the a signed t should I pege 2 hes certificete Physician: this funerel After Attending

Physician

/Medical

Examiner

Examiner

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Completed

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Certification:

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29a. Certifier

(Check only one)

**Physician** 

· /Medical

Examiner

MD

Directo

Funeral

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Completed

**Funeral** 

Director

r than "natural", or items 23s or the Medical Examiner must be

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after deeth with Department of Health and Mental hygiene.

Important if item 27 is marked other than any injury or other traument.

Physician/Medical I To • Funeral D letely filled in

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To the Hosp within 24 hor To the Fune completely fi

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Hospital

State Registrar

31. Data filed (Month, Day, Yaar)

29b. Signatura and title of certifier



R. Shumache M.D. 2309 Shorefield Rd. Wheaton MD 20902



陷 Cartifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, and dua to the ceusa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the causa(s) end manner stetad.

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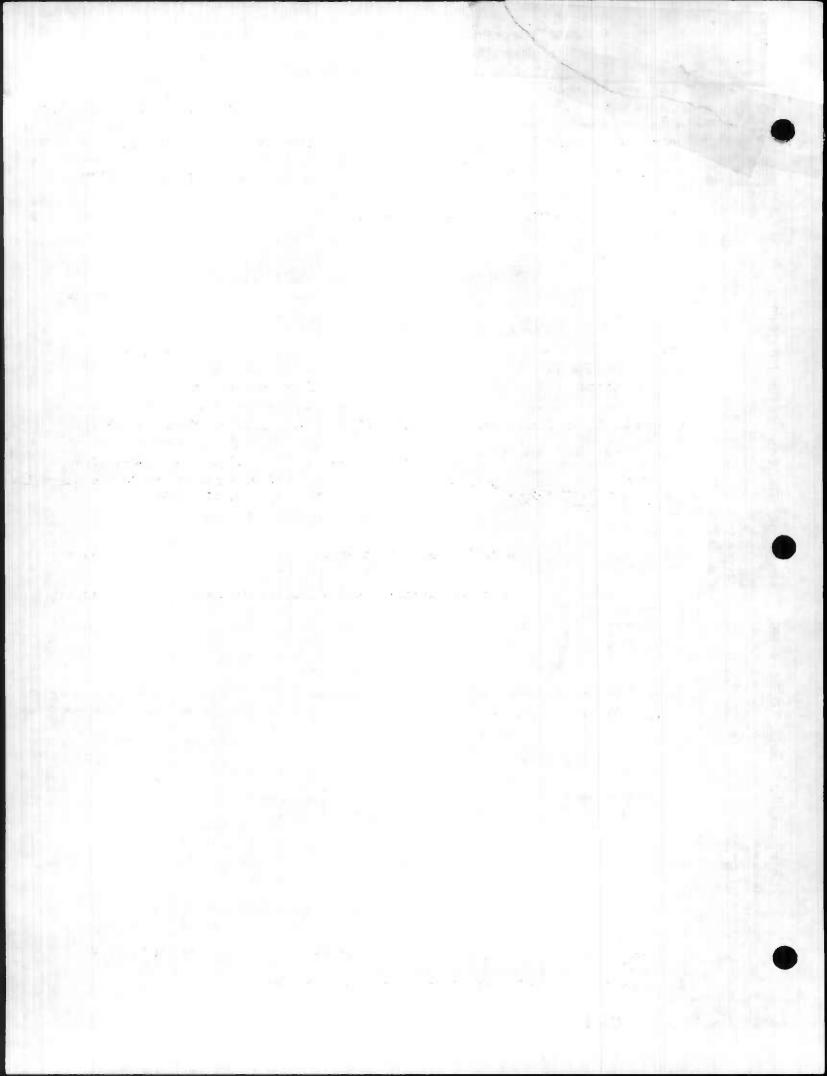
29c. Licansa number

29d. Data signed (Month, Day, Year)

March 9, 1999

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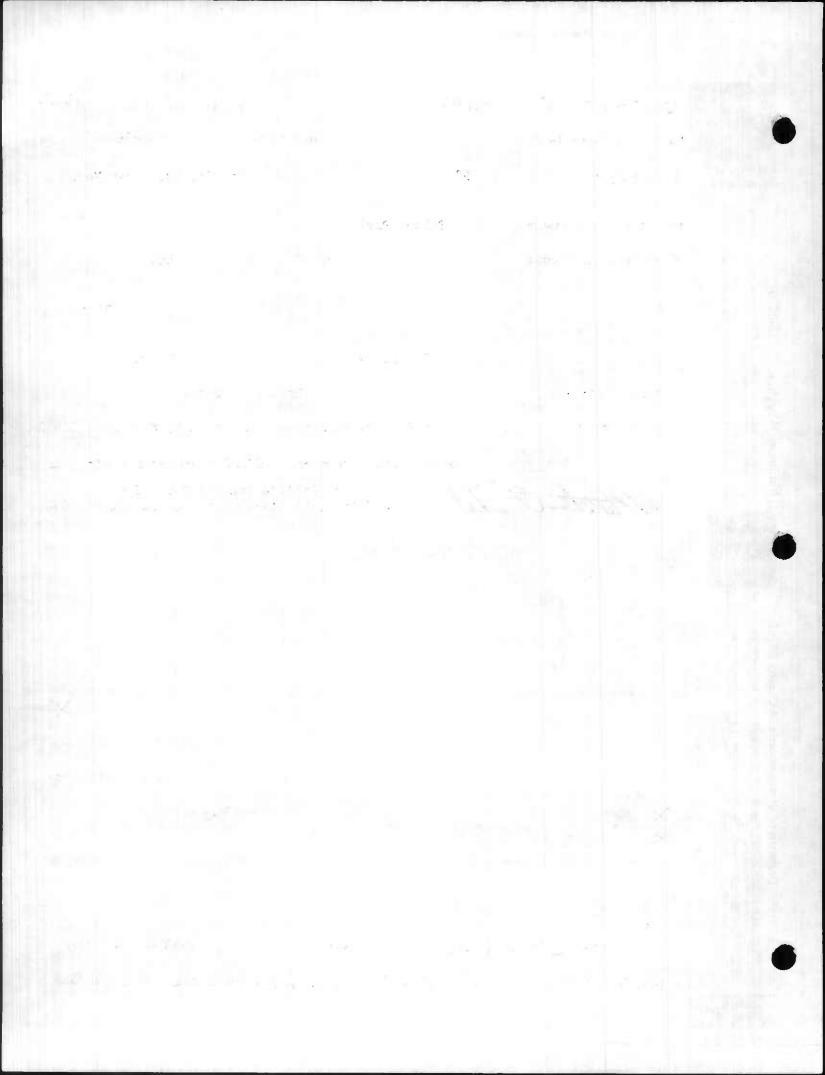
30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)



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			Ce	rtificate of	Death		Re	eg. No.		
hysician	1. Decedent's Nama (First, Middle, La	MAYER	-				e of Deat nth	n Day 05 19	Year	3. Time of Death
/Medical Examiner	4a Facility Nama (If not institution, give GGG BASTEAN B	re street and number)			4b. City, To	wn, or Location	of Death	4c. County	of Death	N.
uneral rector	128-01-7528	Sex   7. Age (In yrs.   1	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. (Mc	e of Birth onth, Day, . 28,		9. Birthp Cour New	**
ž	Usual Rasidenca of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					1	0d. Inside City Lim
or items 23s or 28s-f show miner must be notified at Funeral Director	Maryland Montgom	ery I	akoma	Park		13	11	0g. Citizan of V	What Cour	ty⊡ Yas 2□t
Dir	6600 7								mat oou	,
eral	6603 Eastern Ave	nue 12. Was Decedant Evar in U	IS 13		0912	oin? (Specify Ve	s or No-	USA 14 Bac	e - Americ	en Indian,
*natural', or items 23a edical Examinat must leted by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Armed Forces?  1  Yas 2  No If Yes, Give Yaar or Dates:		Was Decedent of Half Yes, specify Cub		, Puerto Rican,	atc.)		ck, White,	efc.
			16a. Dece	dent's Usuel Occup	pation			16b. Kind of Bu		
other traumatic event, the Medical.  To Be Completed	(Specify only highest green Elementery/Secondary (0-12)	College (1-4or 5+)	(Give life. Secre	kind of work done DO NOT use retire	during mos d)	t of working		Cleri		
E O		)	DECTE	Lary	18. Mothe	r's Name (First,	Middle, N			
o Be	Basil Buccolo				The se	*000 P	M 0 = 5	10		
5	19e. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Street		esa B			State. Zin	Code)
poce.	John A. Mayer  20a. Method of Disposition  1  Burial 2  Cremation 3  4  Condation 5  Other (Special	Removal from Stata	Place of Dispo cemetery, cre	Eastern position (Neme of metory or other plate) tan Crema	ica)	Date	1	rk, Mar 20c. Location - lexandr	Čity or To	d 20912 own, State
cal Examiner	Immediate Ceuse (Final disaese or condition resulting In deeth)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events rasulting in death) Lasf	b Due to (	or es e conser or as a conser or as a conser	quence of):						Onset and Death
by Physician/Med		dcontributing to death but not res	sulting In the u	inderfying cause gi	van in Part	. 23		obacco use co ss 2□ No		o the cause of de
leted						24	a. Was a perforr	n autopsy med?	av	ere autopsy findin- allable prior to impletion of ceuse death?
dwo							1 □ Ye	es 20 No	1!	Yes No
director, page Fo Be Com	25. Was case referred to medical				26. Plece	of Deeth (Chec	k only on			
To B	examiner? 1 Nes 2 No	Hospital:	ER/Outpatie	nt 3 DOA Ot	her:				er (Specia	(y)
=	27. Manner of Death   Natural 5 Pending investigation	ry at ork? ] Yes 2 🗆	28d. D	28d. Describe how injury occurred						
ed in by the funera Certification:	3 Suicide 6 Could not to determined		ome, farm, st	reet, factory, office		28f. Lo	cation (St by or Town	treet and Numb n, State)	per or Run	al Route Number,
edicai (	(Check only 2 Madical Example only only	nysician: To the best of my known in are: On the basis of examine and manner stated.								
¥ com	29b. Signature and fittle of certifier			29c. Licen	ALL STREET		2	9d. Date signe	d (Month,	Day, Year)
	hm	mo. (OME)			5236		N	MARCH	05	1990
	30. Nama and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)	E Pil	(8, Ro	ckui	US M	0	10851
State legistrar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	1	.0 5					

DHMH 16 Rev 6/95



Piease Type or Print in Biack indelibie ink. Assure Ali Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #13/9/99, per physician Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death MC PARTLAND 1:00 PN MARCH **Physician** WILLIAM JAMES /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 24 Hrs. 5. Social Security Number 7. Aga (In vrs. last birthday) If Under 1 Yaar Birthplace (Stata or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Hours Min. Months Days 1⊠M 2□ F Director 046-03-2896 July 24,1916 Connecticut 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinar must be notified at 1 Tas 2 No Directo Maryland Montgomery Potomac 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10810 Gainsbourough Road 20854 USA 12. Was Decedant Evar in U.S. Armed Forcas? 11. Merital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, Whita, etc. 1 ⊠ Yes 2 □ No If Yas, Giva 1941 — Yaar or Dates: 1945 1 ☐ Nevar Married 2K Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: White Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lite. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry permit, Peges 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n eny injury or other traumatic event, the Med page. Bureau of National Elementery/Secondery (0-12) Collega (1-4or 5+) Vice President of Sales Affairs 17. Father's Name (First Middle Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Be Leo McPartland 2 Mary McCann 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 10810 Gainsborough Road, Potomac, Md. 20854 Marlene Bott 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 3/10/99 Alexandria, Va. Metropolitan Crematory 21. Signatura of Funaral Sarvice Lices 22. Nama and Addrass of Facility MONEY & KING VIENNA FUNERAL HOME, INC. 23a. Part 1. Enter the disease, or complication in a caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) CARDIAL ARREST Examiner INFARCTION Examiner MYOCARDIAL attending physician and for use as the burial-transit Sequantially list conditions, if any, leading to immadiata causa. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of Box 68760 Physician/Medicai Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? MALNUTRITION, SEVERE CHRONIC OBSTUCTIVE 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, Completed by PULMONARY DISEASE, PAROXYSMAL ATRIAL 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? FIBRILLATION 1 Yes 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was casa rafarred to medical axeminar?
1 Yas 2 No Be 26. Place of Death (Check only ona) Hospitel: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) Certification: To 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. tnjury at Work? 28d. Describe how injury occurred 1-Neturel 5 Panding invastigation death. 1 ☐ Yas 2 ☐ No To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accidant 6 Could not be datermined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stala) 3 Suicide 28e. Pleca of Injury - At homa, farm, street, factory, office building, atc. (Specify) in 24 hour. 4 Homicide 29e. Certifier 🗠 Certifying Physician: To tha best of my knowledge, deeth occurred et tha tima, data and place, and dua to tha cause(s) and manner as stated. Medical (Check only one) 2 Medicat Examiner: On the basis of examinetion and/or invastigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signatura and title (Certifiar 29c. License number 29d. Date signed (Month, Day, Year) 70 wers rson who complated causa of daeth (Item 23a) (Type, Print) DELRAY AVE BETHESDA, MD 20814 40 MD 30

DHMH 16 Rev 6/95

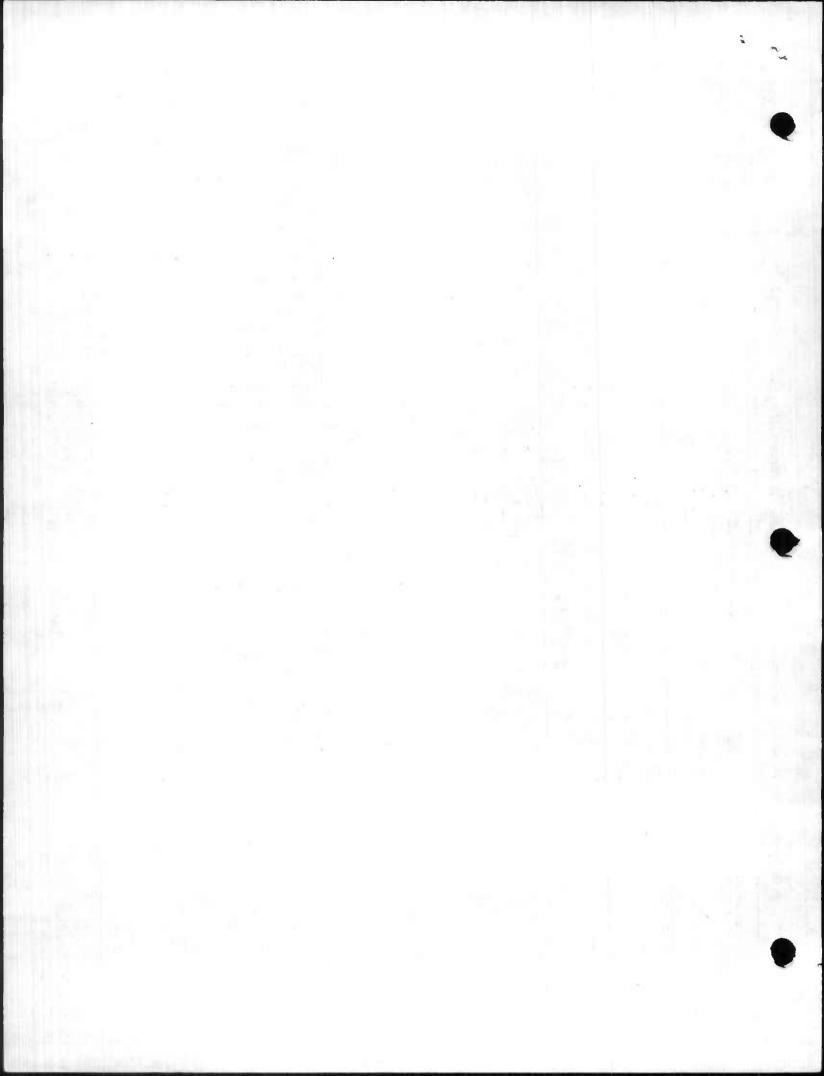
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Registrar

31. Data filed (Month, Day, Year)

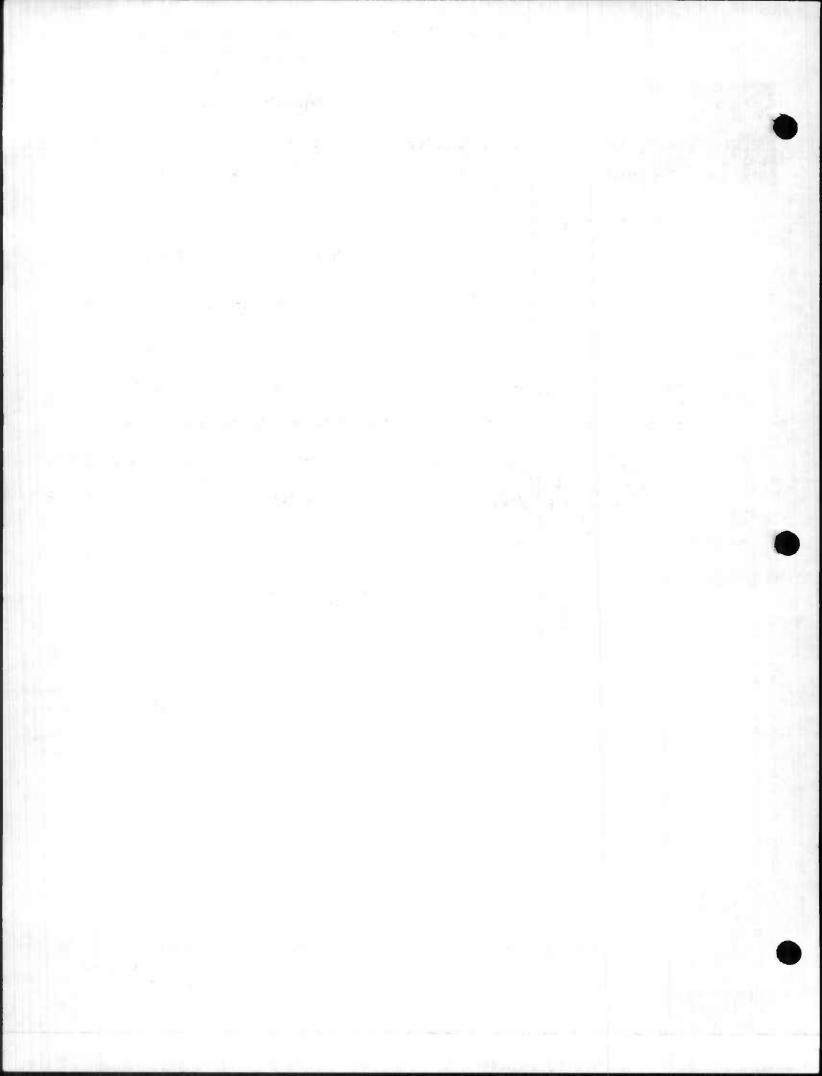
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32. Registrar's Signatura



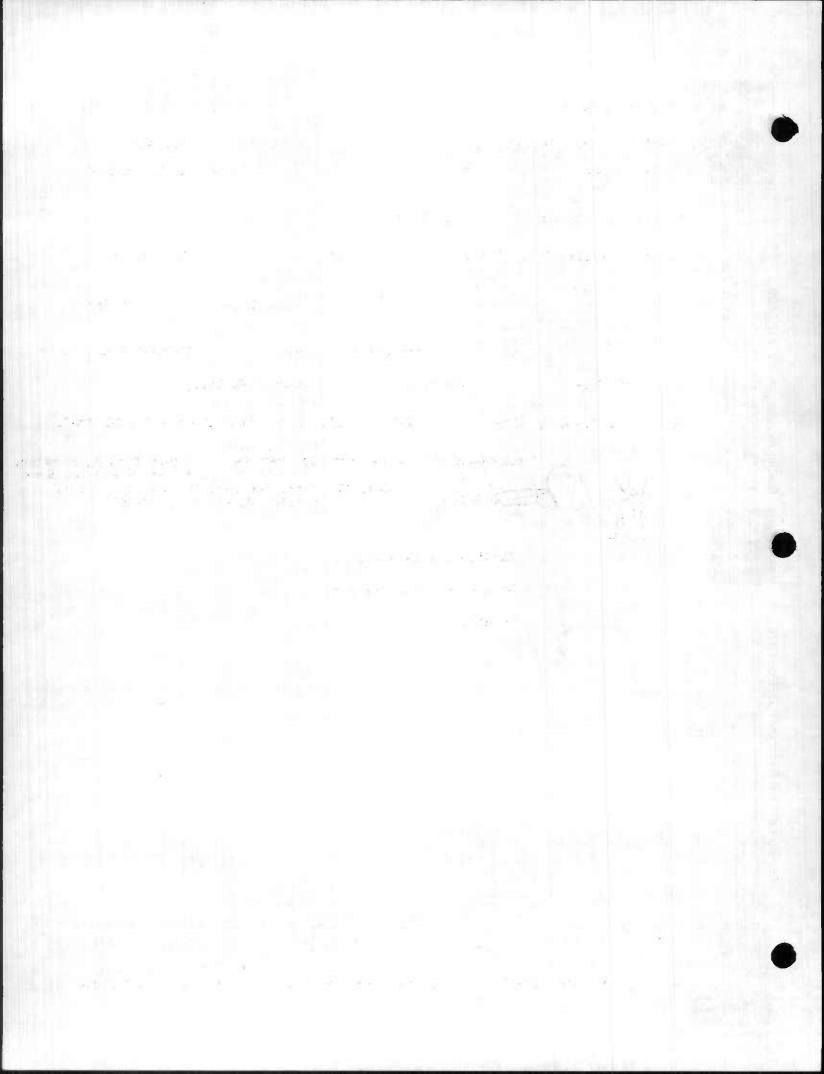
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		Shady Grove Ad					Rockv:	ille MD		tgome	ery
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marked o	2	Froilan C	arranza				Efige		Men		
DE		19a. Informant's Name/Raiationship	(Type, Print)					Rural Routa Numi		, Stata, Zip	Coda)
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of Healt		20a. Mathod of Disposition 1 D Burial 2 TCramation 3 D	Domous I from 1	20b. Plac	ca of Dispo: natary, cram	sition (Nema of natory or other pl	есе)	Mar 10.	20c. Location	City or Tov	wn, Stata
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permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Los	nsee		22	. Nama and Addr	ass of Facility	DeVol Fu	neral H	ome	
SEES		1 Saves To	n U.		10	) Fast D	eer Park	Dr., Ga			D 20877
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/Medical		Immediata Causa (Final	0								
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usit List	Examiner		b. I-DIU	PATHIC		onary	Fibr	2120		-	ears
al-tra	Xa	Sequantially list conditions, if any, leading to immediate cause. Enter UnderlyIng Cause (Disease or Injury		Dua to (or a	s a conseq	uence of):				1	1
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er th		27. Mennar of Death	28a. Data o		8b. Tima of	28c. Inju			how Injury occur		
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r death. ector: Afte by the fune	Hick	3 Suicide 6 Could not b	26e. Piece	of Injury - At home	a, farm, stre	et, factory, office			Straat and Num	ber or Rural	Routa Number,
Dir	ert	4 Homicide	buildin	ng, etc. (Specify)				City or To	wn, Stata)		
within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Pt	nysician: To tha	best of my knowle	edge, daeth	occurred at the t	ime, dete end pie	ce, end due to the	ceusa(s) and m	annar as ste	etad.
Fu letel	edicai	(Check only 2 Medical Examone)	minar: On the be and mann	sis of axamination	and/or Inv	estigation, in my	oplnion, death oc	curred at tha tima	data and place,	and dua to	the cause(s)
withir To th	M	29b. Signatura and titla of certifiar				29c. Lican	sa number		29d. Data signe	d (Month, L	Day, Year)
10		Joseph A Ball	120			D53	212		MARCI	16	1999
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		30. Nama and addrass of person who 16620 frederick			3e) (Typa, I 213	rint)	2. 61	Jose MD 2	pn A. B	all, I	и. и.
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			State of M	aryland		riment o				Reg. No.	) ()	9238
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neral ector	5. Social Security		ax 7. Ag	ga (In yrs. las	st birthday) Yrs.	If Undar 1 Months E	aar If U	singto ndar 24 Hrs. urs Min.	n  8. Data of Birl (Month, Da  December	Montg th y, Yaar) 3, 1922	9. Birth	y Iplaca (Stata or Foreig Intry) Ombia
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eral Director	10a. Stata	10b. County		10c. City,	Town or Loc	ation						10d. Insida City Limit:
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Funeral	11. Marital Status		12. Was Dacedant Armed Forcas?		13. W	as Decedar Yas, specify	t of Hispa <i>n</i> i Cuban, Ma	c Origin? (Sp xican, Puarto	ecify Yas or No Rican, atc.)	- 14. Ha	ce - Amar ack, Whita	ican Indian, , atc.
by F		rried 2⊠ Married 4 □ Divorcad	1 ☐ Yas 2 ☒ It Yas, Giva	No	1	X Yas 2	No Spe	city:		Speci		
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Physician/Medical Examiner	Immediata Ceuse disaese or conditi rasulting in daath)  Sequentially list of any, laeding to i cause. Enter Und Cause (Disasas othat initiated evan rasulting in death)	onditions, immadiate larlying or injury ts	e Cardio b Conges c Pneumo	D-pulm Dua to (or a Stive Dua to (or a	onary as a consequ Heart as a consequ s a consequ	Arres Jence ot): Failu Jence ot):	tre	h as cardiac	Aaryland or raspiretory a	rrast,		Approximate Interval Batween Onset and Death Onset to the cause of death
hysi	Pan II. Other sign	meant conditions co	ontributing to death b	out not rasulti	ing in tha un	dariying cau	se givan in i	ran I.		Yes 210 No	7 7 10	obably 4 Unknow
by				-					24a. Was	an autopsy	24b. V	Vare autopsy tindings vallable prior to
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ation:	1   Yas 2   No   1   Inpatiant 2   ER/Outpatient 3   D   27. Mannar of Deeth   28a. Data of Injury   28b. Tima of Injury   2   Accidant invastigation   M   M   M   M   M   M   M   M   M						Injury at Work? 1 Yes	2 🗆 No	28d. Describe	how injury occi	urred	
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Medical Certification	29a. Cartifiar (Check only one)		ysician: To the best liner: On the basis o and manner st	t axaminatio								
Z e	29b. Signatura	d titia of cartitiar	2 1			29c. L	icansa num	ber		29d. Data sign	ed (Month	n, Day, Year)
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9	20 Nama and	trace othersees up a	completed seven of	loath (Itam 5	(3a) (Tuna 1							
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		ath Day Year)	Kaiser Of	rice,	HOTA	Cross	HOSP:	ical S	liver S	pring,	MD 20	1910

State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** MARCE-HENRY MILLER GEORGE. /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville MD Montgomery Shady Grove Adventist Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Min. | April 30, 1 5. Social Sacurity Number Birthplaca (State or Foreign Country)
 Ohio 7. Age (In yrs. last birthday) **Funeral** 1∏M 2□F Yrs. Director 293-18-9801 74 1924 Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic avent, the Modical Examiner must be notified at 1 ☐ Yes 2 ➡ No Director Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10615 Hunters Chase Lane 20872 United States Funeral 12. Was Decedent Ever in U.S. Acmed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yaar or Dates: WW II Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: 2 Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Depertment of Heelth and Mental Hygiene Important: if Item 27 Is merked other than "re any Injury or other treumatic avant Elementary/Secondary (0-12) College (1-4or 5+) 5+ Executive Chemical Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Rollie C. Miller Fannie Miller 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Rodney C. Miller (son) 19017 Wootton Drive, Poolesville, MD 20837 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 3-8-99 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Nama and Address of Facility
Rapp Funeral Services, P. A. 21. Signature of Funeral Sarvica Licensee Gist Avenue, Silver Spring, MD 20910 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Intarval Between Onsat and Daath **Physician** /Medical SEPTIC SHOCK Immediate Causa (Final disaase or condition resulting in death) Examiner Due to (or as a consequence of) MULTIONGAN STITEM the buriel-transit Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last pue Due to (or as a consequenca of) P.O. Box 68760. ettending physician certificate be Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? Metastatic l'ancrealic Carcinoma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, 8 24b. Wara autopsy findings available prior to complation of causa of death? Liver fairlure Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

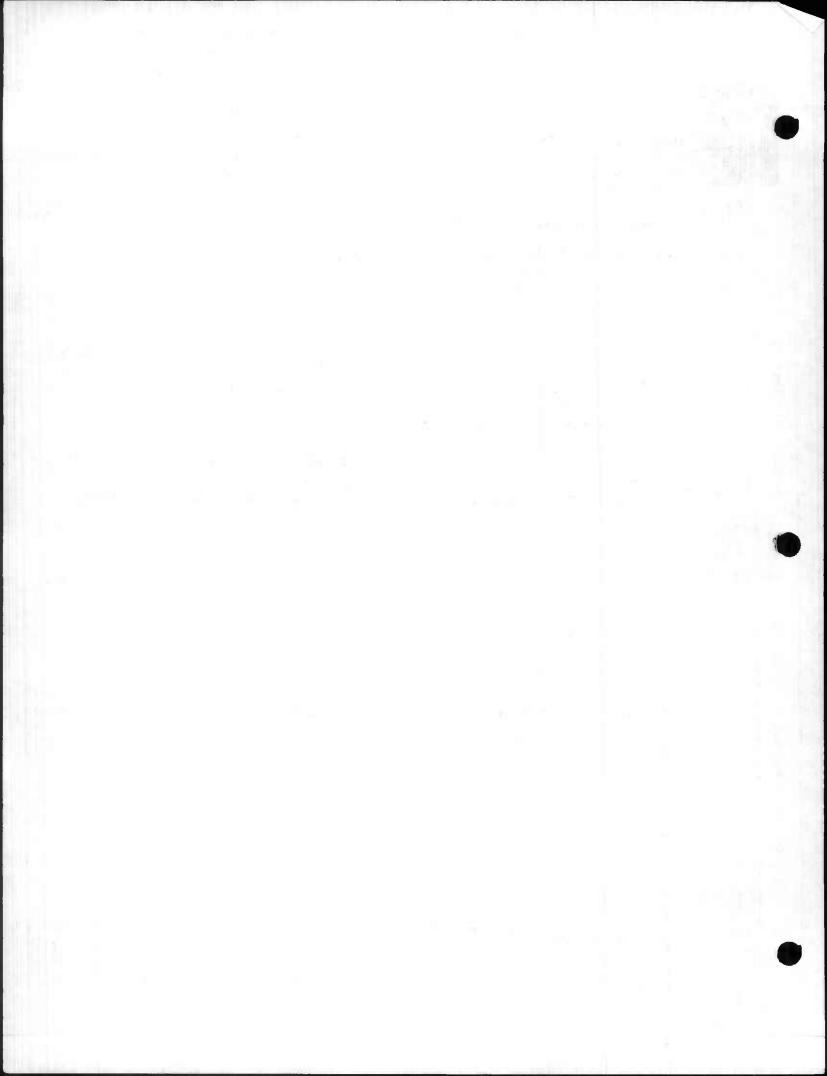
To the Funeral Director: After this certification of the funeral director; the funeral director is the function of the functio Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 1 Yes 25€No Manatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 Pending Investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinerination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner state. 29a. Certifier Jasen 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifier 29c. License number MARCH 07 1999 Bethesda nus 20817 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 7100 Deer Gossing Court. , SAXONA. 31. Data filed (Month, Day, Year) State

Registrar

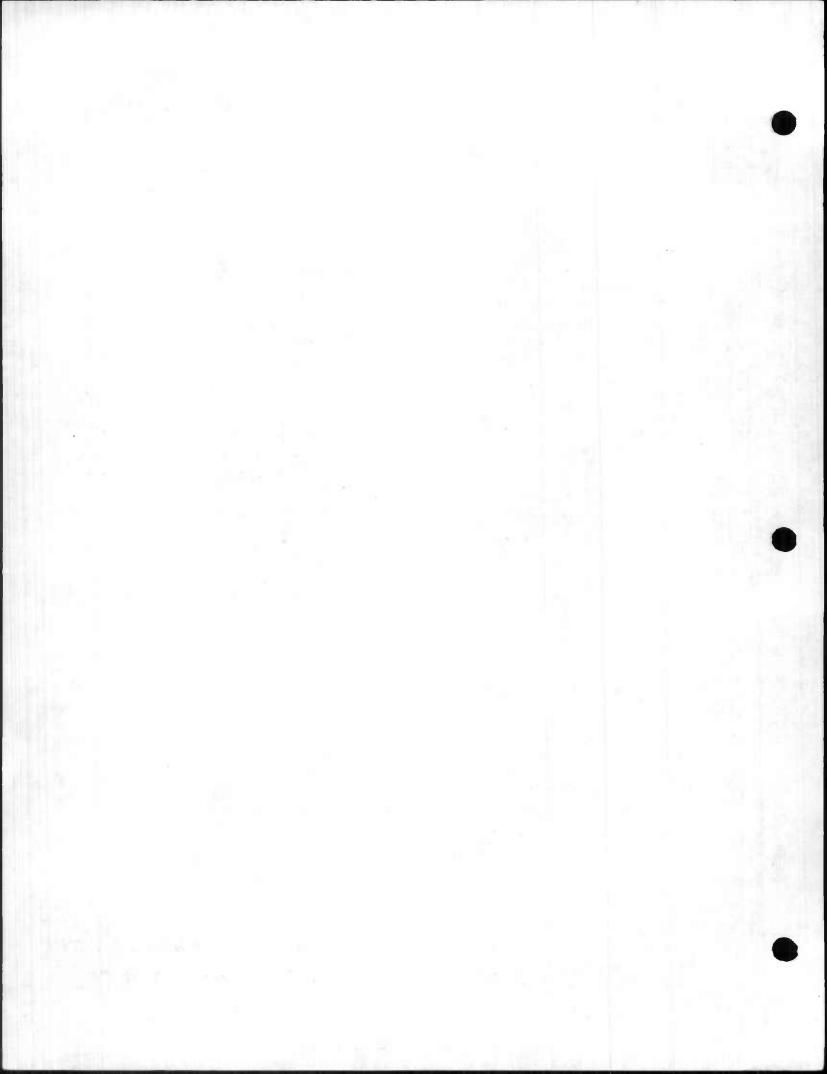
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32. Registrar's Signature



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		ame (First, Middle,						2. Dete of De	eath Day 1	100	of Deeth		
nysician Medical		erma Chee						Marc	4 4 1	999 7:	50 AM		
kaminer	4a Facility Name	e (If not institution,	give street and nu	mber)			4b. City, Town, o	r Location of Deat	h 4c. County	of Death			
		oh Hills			10 5 - 01 - 1 - 3	If Under 1 Yea	Wheaton	re   a D-11 D:		gomery	-		
neral ector	5. Social Security 231–46–5	5762	S. Sex 1 M 2 XF	7. Age (In yrs	Yrs.	Months Days		n. Nov. 29	th ay, Year) 0, 1905	9. Birthplece (Stete Country) Arkansas	or Foreign		
=	Usual Residence 10a. State	10b. County		10c. C	ity, Town or Lo	cation				10d. Inside	City Limita		
rector	MD	Montgom	ery	1.74	Rockv	ille				1 🗆 Ye	s 2No		
Director	10e. Street and N	Number				10f. Zip Code			10g. Citizen of V				
=	702 Sma	allwood R	oad			2085	0		USA	1			
by Funeral		s arried 2☐ Marrie d 4☐ Divorced	Armed Fo	2 🖾 No	H	Vas Decedent of Yes, apecify Cul ☐ Yes 2 ☑ No	Hispanic Origin? (ban, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	Blec	e - American Indian, ek, White, etc. .: White			
Be Completed		15. Decedent's pecify only highest acondary (0-12)		1-4or 5+)	(Give	ent's Usual Occu kind of work done DO NOT use retin	e during most of w	vorking	16b. Kind of Bu	usiness/Industry			
00	17. Father's Nam	ne (First, Middle, La	ist)		Home	incirco 2	18. Mother's N	ame (First, Middle					
o B	James (							Atchley					
_		Name/Relationship			19b. Meilin	g Address (Stree	et and Number or I	Rural Route Numb	er, City or Town,	State, Zip Code)			
	Pamela	M. Hilto	n/daught	er	702 S	mallwood	Rd., Ro	ckville,	MD 2085	50	- 4		
- BUCS	20a. Method of D		По		Plece of Dispos	sition (Name of natory or other pl	lace)	Date	20c. Location -	City or Town, Stete			
		2 ØCremation 3 n 5 ☐ Other (Spe		Me	tropoli	tan Cre	matory	3/11/99	Alexand	ria, VA			
2	21. Signature of	Funeral Service Line Stule	censee				ress of Facility F 500 Uni		. Colling Blvd., V	ns Funeral Vest			
in/Medical Examiner	disease or condinesulting in death resulting in death services and services are services. Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated evenesulting in death	conditions, immediate idenlying or injury ints	a. b. c. d. d	Due to (	or as a consequence as a consequence or a conseq	uence of):	licil.	8					
Cla	0.11.01	141						1 000 000		1			
y Physician/M	Part II. Other sig	nificant conditions	s contributing to de	eath but not res	sulting in the ur	denying cause g	iven in Part I.		Yea 2 No	3 Probably 4	Unknown		
Completed by Physic		F. S.						24a. Wes	en autopsy ormed?	24b. Were autops available pric completion o of death?	rto		
5								10	Yes 2 No	1 ☐ Yes 2	No		
B	25. Was case ref	ferred to medical	Macabil			1-	4 4	eath (Check only	one)				
2		5 ☐ Pending	28a. Date (Mont		28b. Time of Injury	28c. Inj		Home 5 Res	idence 6 Other				
atlor		6 ☐ Could no determin	28e. Plece	of Injury - At h	ome, ferm, stre	et, fectory, office	9		Street end Numb wn, Stete)	er or Rural Route N	ımber,		
Certification	3 ☐ Suicide 4 ☐ Homicide												
completely filled in by the funeral	4 Homicide 29a. Certifier	Cortifying	aminer: On the ba	best of my knousis of examination steted.	owledge, death ation and/or inv	occurred at the testigation, in my	time, date and place opinion, death oc	ce, end due to the curred at the time,	cause(s) end me date end place,	nner es stated. and due to the cause	e(s)		
Medical Certification	4 Homicide  29a. Certifier (Check only)	Certifying 2 Medical Ex	aminer: On the ba	asis of examina ner steted.	ation and/or inv	estigation, in my	opinion, death oc	curred at the time,	29d. Date signed	and due to the cause d (Month, Day, Year,			
Medical Certification	4 Homicid	Certifying 2 Medical Ex	aminer: On the be and many	asis of examina ner steted.	ation and/or inv	estigation, in my	opinion, death oc	curred at the time,	29d. Date signed	and due to the cause d (Month, Day, Year,			



**Physician** 

/Medical

Examiner

Director

Be Completed by Funeral

2

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28s-f show any injury or other treumatic event, ma Medical Examiner must be notified at once.

Plea	se Type or Pr	int in Black	Indelible	Ink. Assure	All Copies	Are Legi	ble.
	State of M		epartment Certificate	of Health and of Death	Mental Hy	rgiene Reg. No.	9 09241
1. Decedent's Name (First, Middle	e, Last)				2. Dete of De	eth	3. Time of Deeth
Herbert Me	rrill Mur	phey			Month	1+ 8 199	Year 0006
a. Fecility Neme (If not institution PENINSULA REGI		*		4b. City, Town, o	r Location of Deat	h 4c. County	
5. Social Security Number  218-16-7572  Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. last birth 73 <sub>Y</sub>	irs. If Under 1 Months I	Year If Under 24 Hr Days Hours Mi	n. (Month. Da	th ay, Year) 30,192	Birthplace (State or Foreign Country)     Maryland
10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
MD Wic	omico		Sali	sbury			1X□X/es 2□No
0e. Street end Number	0.11.1.0.0		10f. Zip C			10g. Citizen of V	Mhot Country?
	ision Str	eet	101. 219 0	21801		-	States
1. Marital Status  1. Never Married 2. Marr  3. Widowed 4. Divorced	12. Wes Deceden Armed Forces ied 1 X Yes 2 If Yes, Give Yeer or Dates	?  No  1/2/16	If Yes, specify	nt of Hispanic Origin? ( y Cuban, Mexicen, Pue () No Specify:	(Specify Yes or No erto Rican, etc.)		ce - Americen Indien, ck, White, etc. y: White
15. Decedent (Specify only highes Elementery/Secondary (0-12)	t's Educetion at grade completed) College (1-4or		Decedent's Usuel (Give kind of work life. DO NOT use	done during most of w retired)	rorking		usiness/industry  truction
7. Father's Neme (First, Middle,	( act)		our pen		eme (First, Middle		
Herbert Mer		hy			Murphy	, Meideri Suman	ne)
9a. Informant's Name/Relations Herbert Murp				Street end Number or F arket St			
20a. Method of Disposition X□XBuriel 2 □ Cremation 4 □ Donation 5 □ Other (S)	3 □Removal from State	cemetery	Disposition (Name crematory or other rn Shor	er piace)	Dete 3/8/99		ck, Maryland
21. Signeture of Funeral Service 1  Millard 7	. 5 bon-		Frampto	Address of Facility OM-Hawkin			
23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ceuse only one cause on each	ed the death. Do no line.	ot enter the mode	of dying, such as cerdi	ac or respiratory a	rrest,	Approximate Interval Between Onset end Death
mmediate Cause (Finel isease or condition esulting in death)	a. Mulh or	gan Xarlun					1
,	0 1	Due to for as a co	onsequence of):				1
	b. Caroli	Due to (or as a co	ick.				
equentially list conditions, any, leading to immediate	A	Due to (or as a co	onsequence of):	1			
buse. Enter Underlying buse (Disease or Injury at initiated events	c. Heu	a MI	Jub and o	Carolla)			
sulting in death) Last	7	Due to (or es e co	insequence of):				1
	c. Acu	rinoug all	220064861	5			1
art ii. Other significant conditio						tobacco usa co	ntribute to the cause of death?
Diabeles	1 vojecterno	was vale	shel abun	e in fast	1 -	Yes 2□ No	3 Probably 4 Unknown
					24a. Was	an eutopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?
					1 🗆	Yes 2 No	1 Yes 2 No
5. Was case referred to medicel examiner?				26. Place of D	eeth (Check only	one)	
examiner? 1 ☐ Yes 2 ☒ No	Hospitel: 1 A Inpat	ient 2 ER/Outp	patient 3 DOA	04	Home 5 ☐ Resi		er (Specify)
7. Menner of Death  1. Naturel 5 □ Pending	28a. Date of Inj	ury 28b. Tir	me of 28c	. Injury at Work?		how Injury occur	

Physician/Medical Examiner To the Hospital or Attending Physician: The lew requires that the death certificete be executed within 24 hours either death.

To the Funneral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burla-transit Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by

**Physiclan** /Medical

Examiner

25. Was ca examin 1 \( \text{Ye} 27. Menne 1X Na Investigation M 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one)

29b. Signature end title of certified

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed ause of death (Item 23a) (Type, Print) BAL ABARNAL, M.D. 614 C EASTER

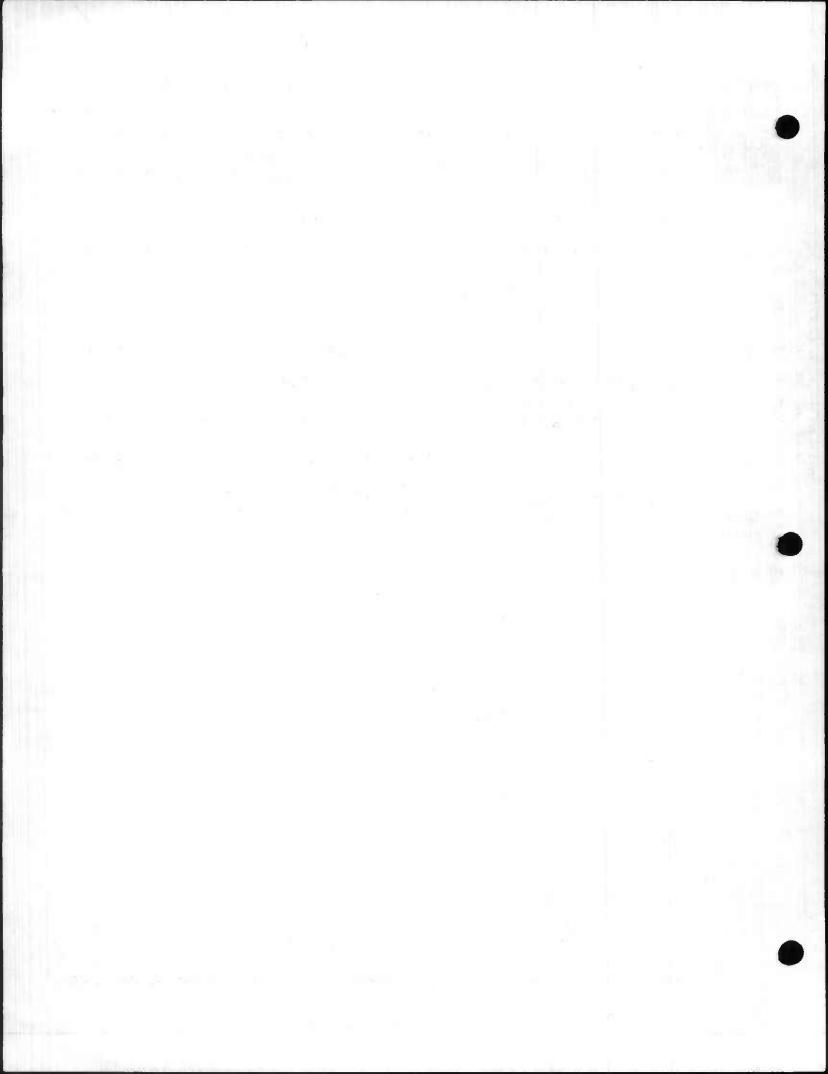
EASTERN SHOVE Dr. SALISBUIN, MS 21804

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAR 1 0 1999

**DHMH 16 Rev 6/95** 



Registrar

**DHMH 16 Rev 6/95** 

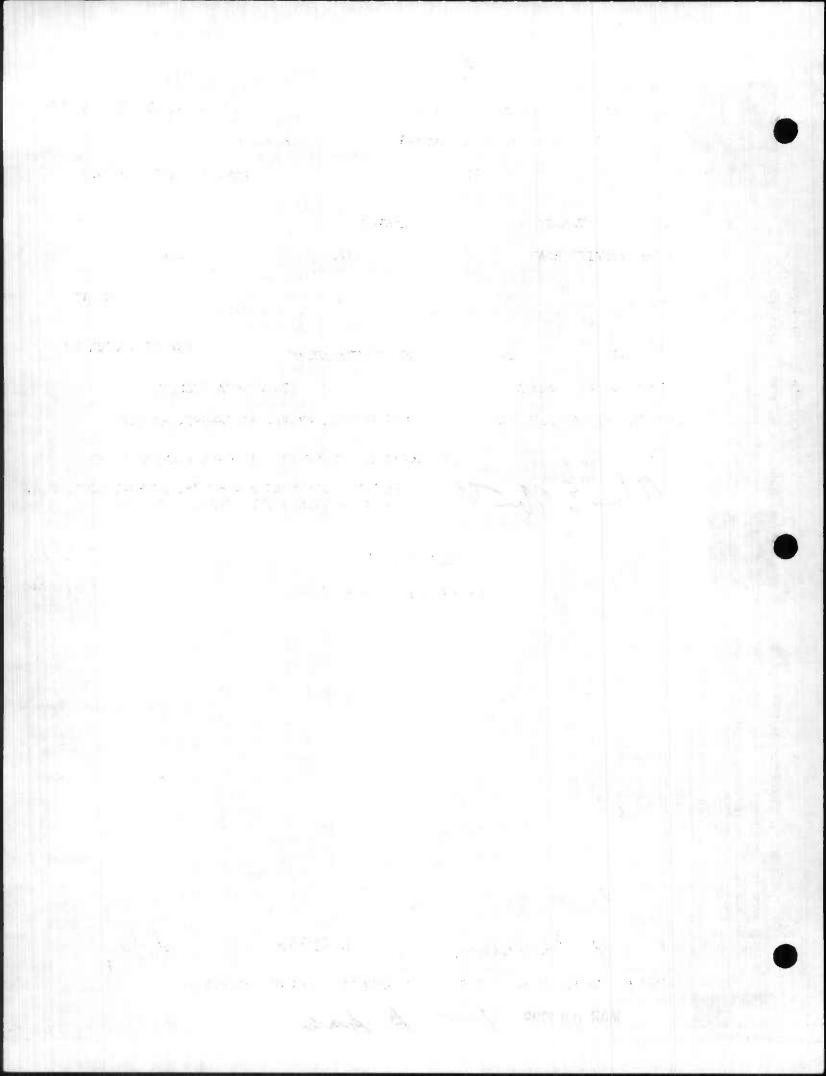
MAR 0 9 1999

Certificate of Death 2. Data of Death 3. Tima of Deeth 1. Decedent's Nema (First, Middla, Last) **Physician** March 7\_ 1999 1210 ARCHIBALD ERNEST MacKAY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, giva street and number) Examiner The Memorial Hospital Talbot Easton If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 6. Sex 1 2 M 2 □ F 5. Sociel Security Number 7. Aga (In yrs. last birthdey) Birthplaca (State or Foreign Country) **Funeral** Months Yrs. 214-14-7367 Director NOV. 26, 1917 CANADA Usuel Residence of Decedent the Maryland 10e. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Marical Examinar mast be notified at 1 Yes 2 No Director TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 612D JEFFRIES ROAD 21601 USA Funeral filed within 72 hours after death 12. Wes Decedent Ever in U,S.
Armed Forcas?
1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indien, Bleck, Whita, atc. 1 Never Merried 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0020 If Yes, Giva Year or Detes: Specify: WHITE by 3 X Widowed 4 □ Divorced Completed 16e. Decedant's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work dona during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) PUBLIC ACCOUNTING 12 5+ ACCOUNTANT/LAWYER 18. Mother's Name (First, Middle, Meiden Surnema) 17. Fathar's Name (First, Middle, Last) should be JOHN GRANT MacKAY EVA WINOTA BECKETT 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury ANNE M. LAWTON/ DAUGHTER 27079 PATRIOT DRIVE, SALISBURY, MD 21801 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Note in the state of the sta NEW CATHEDRAL CEMETERY 3-10-99 BALTIMORE, MD of Scheral Service Licensee 22. Nama and Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601

23a. Pert1. Enter the diseesa, or complications thet caused the deeth. Do not enter tha mode of dying, such as cerdiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediata Causa (Finel disaese or condition resulting in death) /Medical Examiner Examiner physician and the bunal-transit Sequentielly list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or Injury that initiated avents resulting in deeth) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? been signed by the s should be detached 1 Yee 2 No 3 Probably 40 Unknown g 24b. Were eutopsy findings aveilable prior to complation of cause of deeth? 24e. Wes en eutopsy Completed has 2 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 No Division of Vital or Attending Physician: after death. Director: After this certifica 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital e within 24 hours a To the Funersi D Certifying Phyalctan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as stated.

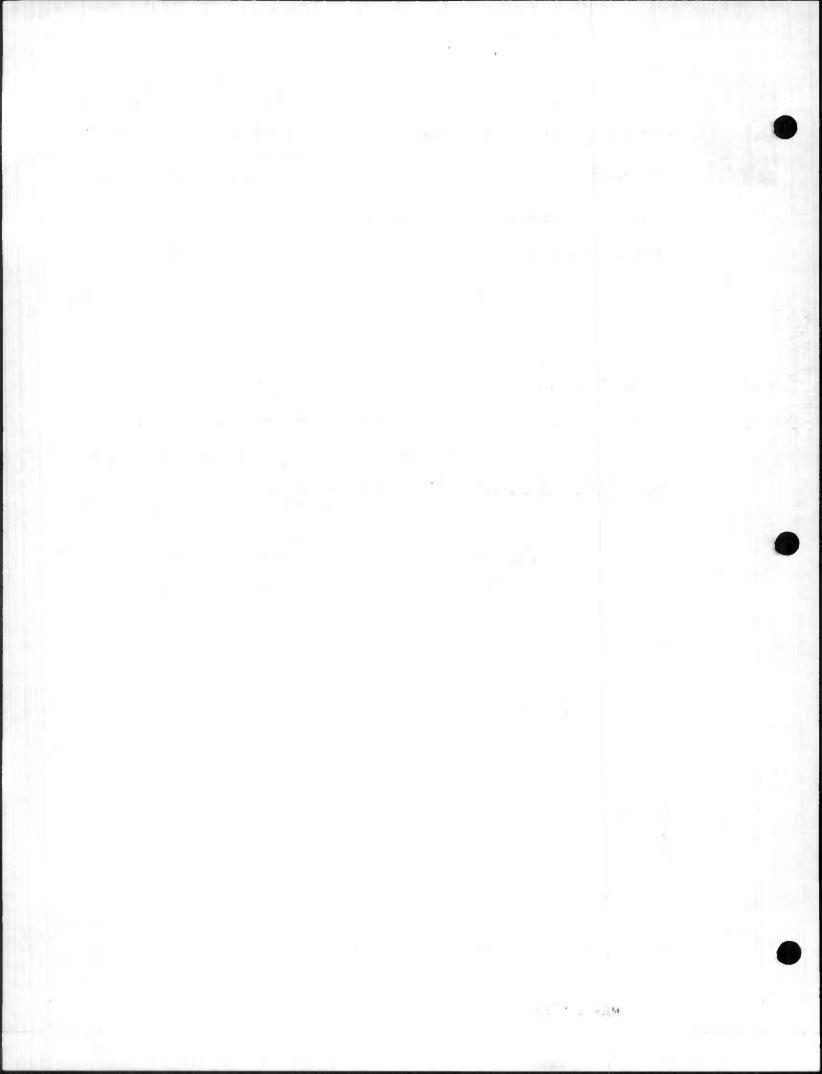
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner stated. edicai 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signetura end title of certifier 52856 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) CYNTHIA RUBIO, M.D., 219 S. WASHINGTON ST., EASTON, MD 21601 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			4 December 10 Norma (First Middle 1 -		Cei	tificate of	Death		Reg. No.		
п	Physic		1. Decedent's Name (First, Middle, Las		DTC			2. Date of Dea	Dey C	y ar	3. Time of Death
ч	/Medi		MILDRED EUN] 4a. Facility Name (If not institution, give		RIS		4b. City, Town, or Lo	cation of Death	4c. County	of Death	1228
7	Exami	ner	PENINSULA REGION		CENTER		SALISB			ICOMICO	)
	Funerai Director		221-09-2400	ex	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day November		9. Birthplace Country) Delawa	e (State or Foreign
	end W		Usuai Residence of Decedent  10a. Stete 10b. County	10	c. City, Town or Lo	cation				10d.	Inside City Limits
	with the Marylend a or 28a-f show be notified at	ţō	Maryland Word	cester	Pocomo	oke City					1 ☐ Yes 2 X No
	or 28a	irec	10e. Street end Number			10f. Zip Code			10g. Citizen of \	What Country?	
	€ 23	ral	2217 Old Snow Hi	.11 Road		2185	51		USA		
Maryland 21215-0020	or its	by Funeral Director	11. Maritat Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cub I □ Yes 2⊠ No	dispenic Origln? (Spe an, Mexicen, Puerto Specify:	ecify Yes or No- Ricen, etc.)	14. Rac Blac Specify	e - American I ck, White, etc.	
5-0	n 72 hours	ted	15. Decedent's Ed (Specify only highest gra	ucation	16a. Deced	lent's Usuel Occup	pation	na	16b. Kind of B	usiness/Indust	ry
121	han han	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of works d)		Domes	tic	
d 2	should be filed withind Mental Hygiena. I marked other than umatic event, the M		17. Father's Name (First, Middle, Last)	0.00	nous	sewife	18. Mother's Name	(First, Middle.	Maiden Suman	10)	
lan	lid be lental ked o	To Be	Walter Elijah Ba	ker			Mary Ja				
ary	permit. Peges 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic. 2016.	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street	and Number or Rura	I Route Numbe	er, City or Town,	State, Zip Coo	de)
	1 and 2 Health em 27 I		Charles R. Conawa	-			St., Sal				
Baltimore,	permit. Peges 1 and Department of Health Important: If Item 27 any Injury or other to once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		natory or other pla		Date 2 / 1 2 / 0 0	20c. Location -		
Itim	it. Pertiment rtant:		4 Donation 5 Other (Specify	L	Concord (			3/12/99	Sear	ord, D	E
Ba	pemit. Peges Department of I Important: If Ite any Injury or of		21. Signeture of Fundai Service Licen	Dean MUI	129 I		-Melson Fu en AVe., F				E1
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	2	deeth. Do not ente	er the mode of dyir	ng, such as cerdiac o	or respiretory er	rest,	Ap Inti On	proximete erval Between aset and Death
1	/Medicai Examiner	ŀ	Immediate Ceuse (Final disease or condition resulting In death)	a Miteal Deterio	and a	orlie	Value	De	cean	4	yrs
Ц		ner		Pa Vonis	to (or es a conseq	uence of):	& Lines	en en la	Die	010 5	ur
	acuted and transi	Examiner	Sequentially list conditions,		to (or as a conseq				· per		
68760,	ificete be executed g physician end es the burial-transit		Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events	C							
587	ficete g phys es tha	edical	that Initiated events resulting In death) Last	Due	to (or as e conseq	uence of):					
Box (	nding use ex			d							
	daath e atte ed for	sicia	Pari II. Other significant conditions of	ntributing to death but no	ot resulting in the ur	nderlying ceuse giv	ven in Part I.	23b. Did t	obacco use co	ntributa to the	cause of death?
P.0	requires thet the death cert seen signed by the attendin should be detached for use	Physician/M	Escuteal						Yes 2/10 No		ly 4 Unknowr
	signed be de	by	2.00	The second		20	н.				
Records,	> 10	Completed	Bilateral	Rema	lenno el Ez	Guns	-M_	24e. Wes	en autopsy med?	availab	autopsy findings ole prior to etion of cause th?
R	ysician: The law r is certificata has b director, paga 2 st	Com						1 🗆 Y	es 2 No	1 □ Ye	es 2 No
Vital	artifica ctor,	Be C	25. Was cese referred to medicel examiner?				26. Place of Death	(Check only o	ne)		
of \	Physician: r this certific rral director,	P_	1 ☐ Yes 2 X No	Hospital: 1 Inpatient	2 ER/Outpatien		4 Li Nuising no				
nc	After funer	ion:	27. Manner of Deeth  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Dey Yea	ar) 28b. Time of Injury	28c. Injur Wor	ry at rk? Yes 2 □ No	28d. Describe h	now injury occur	red	
Division of	or Attendiffar deetl	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		28f. Location (S City or Tow	Street and Numb m, State)	er or Rural Ro	oute Number,			
	To the Hospital or Attending Phys within 24 hours after deeth.  To the Funeral Director: After this completely filled in by the funeral di	edicai Ce	29a. Certifier (Check only one)  29a Certifying Phy 2 Medicel Exam	relcien: To the best of my liner: On the besis of exa and manner stated.	/ knowledge, death minetion and/or inv	occurred et the tir	me, date and plece, a	and due to the ded at the time, d	cause(s) and me date and place,	enner as stated and due to the	d. ceuse(s)
	ro the	Me	29b. Signature and title of certifier	7	05	29c. Licens	se number		29d. Date signe	d (Month, Day	, Year)
	, - 0		Legenses 1	15ell	- his	J DZ	9505		3-8	7-99	
			30. Neme and address of person who o								
-		Q	GREGORIO M. BEL  31. Date filed (Month, Day, Year)	LOSO, M.D.;	5302 CH	INABERI	RY DR., S	BALISB	URY, M	(D 21	801
	Sta	ite	31. Date filed (Month, Day, Year)	32. Pégistrar's S	Signature	See. 4	11				



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

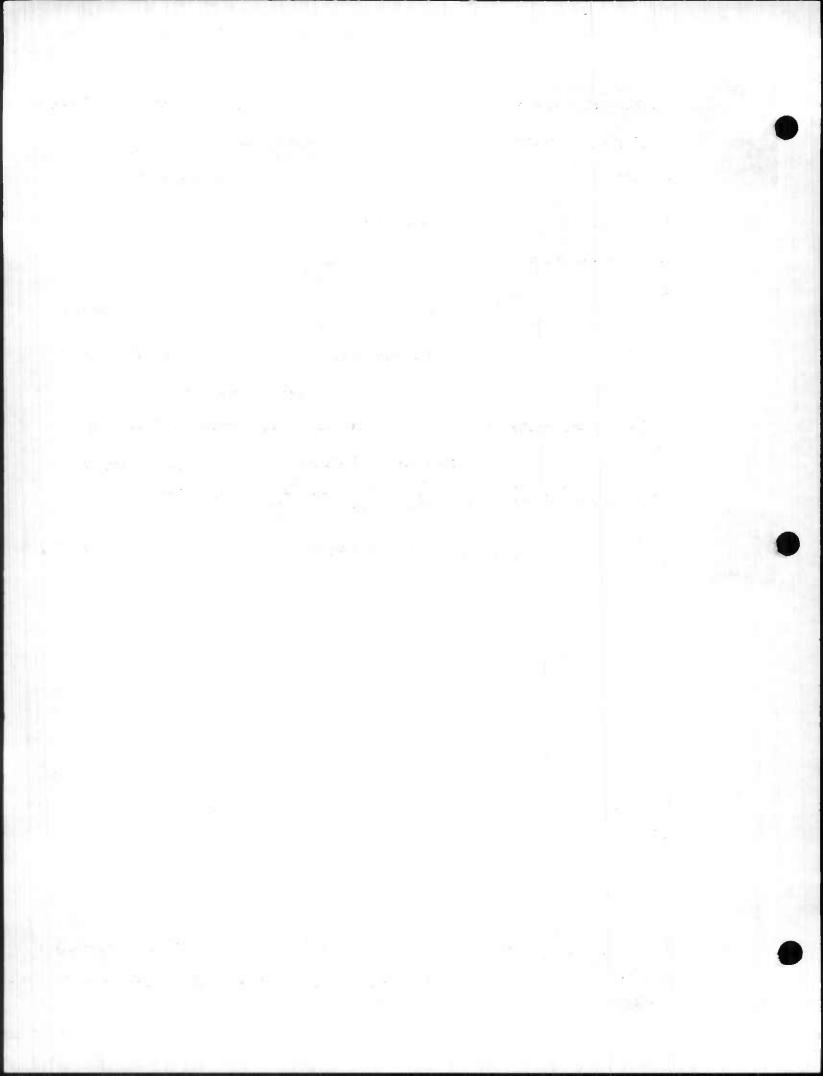
	1. Decedent's Nan	ma (First, Middle, La	ist)		Cer		П		2. Data of De			3. Time	of Deeth
Physician	DOUGLA	S STANFO	RD MAY						Month	Day 3. 1999	Year	5:20	D m
/Medical Examiner	4a Facility Name	(If not institution, given	a street and nun	nber)			4	4b. City, Town, or			ty of Death	1.0.0 4.11.	-Pallia-
	Memoria	1 Hospita	al & Med	ical Ce	enter			Cumberla		Alle	gany		
uneral	5. Sociel Security		Sex	7. Age (In yrs.		If Under 1	Year Days	If Under 24 Hrs Hours Min		rth ay, Year)	9. Birth	place (Stete intry) LAND	or Foreign
irector	214-07-21 Usual Residence	0.37	ACIW 201	89	Yrs.				JAN 30	1910	MARYI	LAND	
B 10	10a. State	10b. County		10c. Cit	y, Town or Lo	cation	-					10d. Inside	City Limits
tor tor	MARYLAND	ALLEGA	NY	С	UMBERL	AND						1 XX	s 2 No
"natural", or items 23a or 28a-f show soldal Examinar rough as notified at leted by Funeral Director	10e. Street and Nu	umbar				10f. Zip C	ode			10g. Citizen o	What Cou	intry?	
23a o	715 SY	LVAN_AVEN	IIF			2	150	12		U.S.	Δ		
r Kema 23. drer tour	11. Marital Status	DVIIII IIV DII		dent Ever in U	,S. 13. V			lispanic Origin? (3 an, Mexican, Pua	Specify Yas or No	o- 14. Re	ce - Amer	ican Indian,	
S. P.		rried 2 Married	1 X Yas	2 No		☐ Yas 20			,	Spec		ITE	
d by	3	4 Divorced	Year or Da	ates: WW1									
Completed	(Spe	15. Decedent'a E ecify only highest gr	ducation ade com <i>pleted)</i>		16e. Deced	ent's Usual (	done o	eation during most of wo d)	orking	16b. Kind of	Business/ii	ndustry	
dm dm	Elementery/Sec	condary (0-12)	College (1	-4or 5+)				on #1024		CARR	מ כו מות אינו		
CO	17. Father's Name	(First, Middle, Las	)		CARLER	IERS_	OINT		t nme (First, Middle		ENTER		
To Be	HARVEY	M MAY						HEST	TER H. H	OLLER			
Tangar Tangar	19a. Informant's N	Name/Relationship	Type, Print)		19b. Mailin	g Address (S	Street	end Number or F	Rural Route Numb	er, City or Tow	n, Stete, Z	ip Code)	
Important: If item 27 is marked other than any fnjury or other traumatic event, the Mones.  To Be Comp	CARL BEF	RNDT		SON	18 EA	ST TH	IRD	STREET	WAYNESB	ORO, PA	. 172	68	
e e	20a. Method of Dis	•	Damen dan d		Place of Dispo-	sition (Neme	of er plea	ce)	Date	20c. Location	- City or T	own, State	
o Au		Cremation 3 ☐ 5 ☐ Other (Speci			BARGER	CEMET	ERY	MARCH 6	1999	HYNDMA	N, PA		
any fnji	21. Signature of F	uneral Servica Lice	nsee	11	22 M F	Name and	Addre	ss of Facility AMS FUNI	PAI HOM	F D A			
ESS	M	ale L.	Wern	a				R STREET			RYT.AN	ID	
	23a. Part 1. Enter	the disease, or con art failure. List only	plications that co	aused the deat								Approxim Interval B	etween
sician												Onset an	d Daath
ledical aminer	Immediate Cause disease or conditi	ion	BILAT	TERAL P	NEUMON:	IA						3 DAY	S
	resulting in deeth)	)		Due to (d	or es e conseq	uence of):							
n end iel-trensit Examlner		-	b										
physician end s the buriel-trensit edical Examir	Sequentially list c if any, leeding to l cause. Enter Und Cause (Disease o	onditions, Immediate		Due to (d	or as a conseq	uence of):					i		
	Cause (Disease of that initiated even	or injury	C	Duo to /o	r as a conseq	uanca off:					+		
3 65	resulting in death)	Last		Due to (c	as a consequ	uerice orj.							
for use			d	_		-					1		
ed for	Part II. Other sign	ificant conditions	contributing to de	ath but not res	ulting In the ur	nderlying cau	se giv	en In Part I.	23b. Did	tobacco use o	ontributa	to the caus	e of death?
should be detached for use leted by Physician/M									1	Yes 2 No	3 🗆 Pr	obably 4	Unknown
be de by F									-				
ponio per									24a. Was	s an eutopsy ormed?	8	Vere autops	or to
pege 2 should											0	completion of death?	r Cause
Con									10	Yes 2 No	1	☐ Yes 2	□ No
Be (	25. Was case refe examiner?	erred to medical	Hear hall				6		eath (Check only	one)			
completely filled in by the funeral director, page 2  Medical Certification: To Be Comp	1 ☐ Yes 2 2				ER/Outpetien		-	4 Li Nursing	Home 5 Res			cify)	
fune	27. Manner of Dec	5 Pending		of Injury h, Dey Yeer)	28b. Time of Injury	M 280	. Injur Wor	rk? Yes 2 □ No	28d. Describe	how injury occ	urrea		
led in by the funer.	2 Accident 3 Suicide	investigation		of Injury - At h	ome farm str			100 2 100	28f. Location	(Street and Nu	nber or Ru	rel Route N	umber,
ent	4  Homicide	determined	buildir	of Injury - At h	y)	001, 10010171	511100		City or To	wn, State)			
S S S S S S S S S S S S S S S S S S S	29a. Certifier	12 Certifying Pi	nysician: To the	best of my kno	wiedge, death	occurred at	the tir	me, dete and plac	ce, and due to the	cause(s) and	manner es	stated.	
pletely fill	(Check only one)	2 ☐ Medical Exa		isls of examina har statad.	tion and/or Inv	estigation, ir	птуо	opinion, deeth occ	curred at the time	, dete and plac	a, and due	to the ceus	9(s)
To the Function Director: After this certificate has completely filled in by the funeral director, page 2  Medical Certification: To Be Comp	29b. Signature an	d title of certifier	-			29c. l	Licans	sa number		29d. Data sig	nad (Montl	n, Day, Year	)
9	-	Think	no			D	33:	280		March	4.	, 10	999
		1-1-		o of death (Iter	n 23a) (Tyna	1					1/	,	
/	30. Name and add	fress of person who	completed caus	e or death (ite	11 200) (1 ypo,	rinity							
nes		pta, M.D.					Bu	ilding,	Cumberla	and, MD	215	02	

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200 6 7 Mg. .

State of Maryland / Department of Health and Mental Hygiene 9 09245

						Certifica	te of	Death	F	Reg. No.	0 3 6 4	
P	Physici	an	Decedent's Name (First, Middle, Las     JOHN EDWARD MA						2. Date of Dea Month Mar 9		3. Time o	
	/Media	cal						th City Town or I		1		40 pm
	Examir	ner	4a. Facility Name (If not institution, give					4b. City, Town, or L				
			1103 HOLLAND ST 5. Social Security Number 6. Se		e (In yrs. last bi	irthday) If Und	er 1 Yea	CUMBERLA r If Under 24 Hrs.		ALLEGA		or Foreign
Di	unerai rector			<b>Ž</b> M 2□F	76	Yrs. Months	Days	Hours Min.	8. Date of Birth (Month, Dey Sep 1	2, 1922	Birthplace (Stete Country) MD	or r oranger
hend	M W		10a. State 10b. County		10c. City, Tov	vn or Location					10d. Inside C	City Limits
Man	13	tor	MD Allegany	7	Cu	mberlan	d				1 XYes	s 2□No
th the	23e or 28e-f show	Director	10e. Street and Number			10f. Z	ip Code		1	log. Citizen of Wha	Country?	
th wi	230	alc	1103 Holland Str	eet			215	02		USA		
ter de	rel', or items: Examiner ro	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 XYes 2 N			edent of ecity Cul	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- Rican, etc.)		Americen Indian, Vhite, etc.	
Ours a	P. C.	by	3 ☐ Widowed 4 ☐ Divorced		WW II	1 🗆 Yes	2 X No	Specify:		Specify:	white	
Z I Z I 3-UUZU d within 72 hours af giene.	than "naturel", The Medical Ext	Completed	15. Decedent's Edu (Specify only highest grad	cation		Decedent's Us	ual Occu	ipation a during most of work	cina	16b. Kind of Busine		
within ene.	then he	nple	Elementery/Secondery (0-12)	College (1-4or 5	+)	life. DO NOT	use retin	ed)	,g			
		ဝိ	12		Re	etired E	mplo	-	- 17 - 300 71		y County	
2 2	9 >	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle,	Maiden Sumeme)		
should be nd Mental	marked metic e	2	Asa G. Martz						(Billin			
12 sho	2 E		19a. Informant's Name/Retationship (T)					et end Number or Ru				
	Itam 27 other t		Regina M. Davis-	-sister		LOIOI HI of Disposition (N		rest Drive	Dete Cumbel	rland, MD 20c. Location - City		
Depertment of Hea	I III		1 DBurial 2 □ Cremation 3 □ F	Removal from State	cemete	ery, cremetory or	other pl			200. Location - Oily	or rown, state	
it. P	njur)		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens		SS Pe	eter Pau		metery	03/13	Cumberla	and, MD	
permit. P	Important: If It any injury or o		Dames 7	Sca	roell	Sca	arpe.	lli Funera land, MD	al Home, 21502	P.A.		
Dhoo	-1-1		23a. Part 1 Enter the disease, or comp shock, or heart failure. List only o	lications thet caused ne cause on each lin	the death. Do	not enter the mo	de of dy	ring, such as cerdiac	or respiretory en	est,	Approxime Intervet Be Onset and	tween
/Me	sician edical		Immediate Ceuse (Final disease or condition	CANCE	n 0:	+ pros	TKI	E			YEA	RS
Exar	miner	_	resulting in death)	ы		consequence of						
P	ısı	-lue		b								
rificate be executed	physiclen end s the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or as e	consequence of	):				1	
ificate be ex	physic the bi	Physician/Medical	Cause (Disease or Injury thet initiated events resulting in deeth) Last	C	Due to (or es a	consequence of	):					
. E	0 40	√Me	L.	d							<u> </u>	
death ce	attendir d for use	clar	Port II Other significant conditions as	stelleration to steetle lev				to a la Bank l	ook Dida			
thet the	signed by the a	hys	Part II. Other significant conditions con	ntributing to death bu	it not resulting i	in the underlying	cause g	Iven in Pert I.	235. Did to	obacco use contrit	Probably 4	
s the	peng ep ec	by F						<u> </u>				
inbe	should	Completed							24a. Was e perfor	on eutopsy med?	4b. Were autopsy evalleble prior completion of of death?	to
The law	ate hes page 2	m C							1 🗆 Y	es 2 No		No
	certificate rector, pag	BeC	25. Was case referred to medical					26. Place of Deal			10 105 20	) 140
	is certific director,	To B	evaminer?	lospital:	nt 2□ER/O	utpatient 3 🗆 🖸	OA O	ther		ence 8 Other (	Snecify)	
l or Attending Physeler death.	Diractor: After this	Certification: T	27. Manne of Deeth 1 ☑ Naturel 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b.	Time of Injury	28c. Inju			ow injury occurred	роспу)	
Attending or death.	y the	ficat	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Plece of Inju	rv - At home fa				28f. Location (S	treet end Number o	r Rural Route Nun	nber.
or A efter	d in b	ent.	4 Homicide determined	building, etc	. (Specify)	21111, 311001, 10010	, onice	·	City or Tow	n, Stete)		,
To the Hospital within 24 hours e	To the Funeral Dir completely filled In	edical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 1 Certifying Physical Examination (Check only one)	ner: On the basis of	examination er	e, deeth occurre nd/or investigetio	d et the t	ime, dete end place, opinion, death occur	end due to the c red at the time, d	euse(s) end menne late end plece, and	r as stated. due to the ceuse(	s)
o the	o the	Me	29b. Signature and title of certifier	end manner sta	iou.	2	9c. Licen	se number	2	29d. Date signed (N	Ionth, Day, Year)	
F≯F			7/m/n/sh	m			DU					5
	8		30. Name and address of parson who as	mpleted cause of de	ath (Itam 23a)	(Type Print)	4	. ( / /		1 041	10/1/0	/
1	MAS		VIRGINA 6.	WAR BIJO	s, no	9/2	Si	TON OR	WE C	umste	AND, W	4) 21
	Sta Registr	-	31. Date MAR 11 02. 1999	32. Registra	r's Signature	do						



				Certificate of	f Death		Reg. No.		2640
	1. Decedent's Neme (First, Min	ddie, Last)				2. Dete of D	eeth Dev	Yeer	3. Time of Death
nysician Medical	Elsie E. Moore					Febru		1999	12:15 E
edicai miner	4e Fecility Neme (If not institu	tion, give street and nur	nber)		4b. City, Town,	or Location of Dee			1 1 1 1 1 1
	Memorial Hos	nital			Cumber	·land	A1	legar	nv
	5. Sociel Security Number	6. Sex	7. Age (In yrs. last birthe	Months Dev	or   If Under 24 l				plece (Stete or Foreigntry)
	220-03-7700	1□ M 2⊠F	79 Yr	Months Dey	s Hours IV	21-Ap		Mary	
	Usual Residence of Decedent					2114			
	10e. State 10b. Coul	nty	10c. City, Town of	or Location				1	l Od. Inside City Limit
Director	Maryland /	Megany	Mount So	vage					1 Yes 2 □ N
	10e. Street and Number	17 Woodoook	Hollow Road,	10f, Zip Code			10g. Citizen of	Whet Cour	ntry?
	123	17 WOODCOCK	HOROW ROUG,	215	545-		U.S.A		
Funeral	11. Maritel Stetus	12. Wes Dece Armed Fo	edent Ever In U,S.	13. Was Decedent of	Hispanic Origin?	(Specify Yes or N	o- 14. Ra		cen Indien,
-	1 ☐ Never Married 2 ☑ M		2 No	1 ☐ Yes 2 ☑ N			Specif		
	3 Widowed 4 Divord	ed Year or D	etes:		·			White	
	15. Deced	ant's Education hest grade complated)	16e. D	ecedent's Usual Occ	upetion le during most of	working	16b. Kind of B	usiness/In	dustry
-	Elamantary/Secondary (0-12		-4or 5+)	Give kind of work don fe. DO NOT use reti	red)				
Toold III	12	0	Hom	emaker			Homema		
Be	17. Fether's Neme (First, Midd	le, Last)			18. Mother's	Neme (First, Middle	a, Maidan Sumer	ne)	
9	George A. Bridg	es			Elizat	eth Meyers	3		
	19e. Informent's Neme/Reletic	onship (Type, Print)	19b. A	failing Address (Stre	et and Number o	r Rurel Route Numi	ber, Cify or Town	, Stete, Zip	Code)
	William A. Moor	B Husband	1.600171	Voodcock Holl	low Road	Mount Sa	vage Man		21545-
	20e. Method of Disposition  1 ■ Buriel 2 □ Cremetic	n 2 Domewel from	cometerv	isposition (Neme of cremetory or other p	lece)	Dete	20c. Location	- City or To	own, State
	4 Donetion 5 Other			emorial Park		01-Mar-99	Frostburg	. Man	rland
	21. Signature of Funeral Servi	on Lipenson		22. Name end Add	lress of Fecility				
	Volum 7	( 1) wet	18	<b>Durst Funero</b>	al Home, 5	7 Frost Ave.	Frostburg	MD 2	21532
	23a Parl1. Enter the diseese hock, or heart teilure. L	or complications that c	aused the deeth. Do no				_		Approximata
	mhock, or haart teilure. L	ist only ona ceuse on e	ech line.					3	Intervel Between Onset end Deeth
	Immediate Cause (Final								
	diseasa or condition resulting in daeth)	e ISCH	EMIC BOWEL  Due to (or es a co	neadlenea of):				1	5 days
Jer		15100						1	. 1
Examiner	Convention list conditions	b. MYOC	ARDIAL INFA  Due to (or es e co					1 (	days
EX	Sequentielly list conditions, if eny, leeding to Immediate ceuse. Entar Underlying Cause (Disaase or injury	OFFIC	200 - Inni-i	Carlo Carlo				1	6 days
edical	that initiated events	C. CERE	BROVASCULAR Due to (or es e cor					1	days
	resulting in daeth) Lest		Due to (or es e cor	isoquerice ory.				1	
3		d						1	
cia	Port II Other sleatiles at a set	Mone containstance	noth but not seculities to	ha undarhing	airon la Dant I	OSE DI-	I tobacco use to	antribute t	o the course of deat
Physician/	Pert II. Other eignificant cond	more contributing to de	en out not resulting in t	ie underlying ceuse (	given in Felt I.		Yes 2 No		to the cause of deat
					Jan 100 100 100 100 100 100 100 100 100 10	11.	1105 ZLI NO	3 L Pro	TOURNS THE UNKNOWN
d by						24e. We	s en eutopsy	24b. W	ere eutopsy finding
Completed						per	formed?	CC	reileble prior to empletion of cause
D									death?
							Yes 2 No	1	Yes 2 No
Be	25. Wes case referred to med examiner?	t to a chart		_ 10	Other:	Daeth (Check only			
Lo	1 Yes 2 No	1121	npatient 2 ER/Outp	atient 3LI DOA	4 LI NUISII	ng Home 5 Res	sidence 6 □Ot how Injury occu		fy)
0	27. Manner of Deeth  1 Manual 5 Pen		of Injury th, Dey Year) 28b. Tin	iry W		260. Describe	now injury occu	III	
Cat	L LI MOOIDOIN	stigetion			☐ Yes 2☐ No	COS I continu	(Character of Alice	has as floor	of Boute Atumber
Certification:	4 Homicida data	mined 28e. Plece buildi	of Injury - At home, fem ng, etc. (Specify)	i, street, tectory, offic	<b>:</b> e	City or To	(Street end Num own, Stete)	Der DI MUI	al Route Number,
2			1						
edicai	(Check only 2 Medic	al Examinar: On the ba	best of my knowledga, on the state of examination and/						
9	one)	end mani	ner stated.						
Σ	29b. Signeture and title of cert	fler		29c. Lice	inse number		29d. Date sign		
	/	1 hal		D 3	36766		March	21,	1199
	30. Neme end address of pers	on who completed caus	e of deeth (Item 23e) (T						
7	Dr. V. Poonai	, 920 Natio	onal Highwa	y, LaVale,	MD 21.	502			
te	31. Dete filed (Month, Day, Ye	ar) 32,R	egistrer's Signature	1					
ar	MAR 0 5	1999	person of.	A STATE OF THE STA	4				
5/95									

Elsie E. Moore

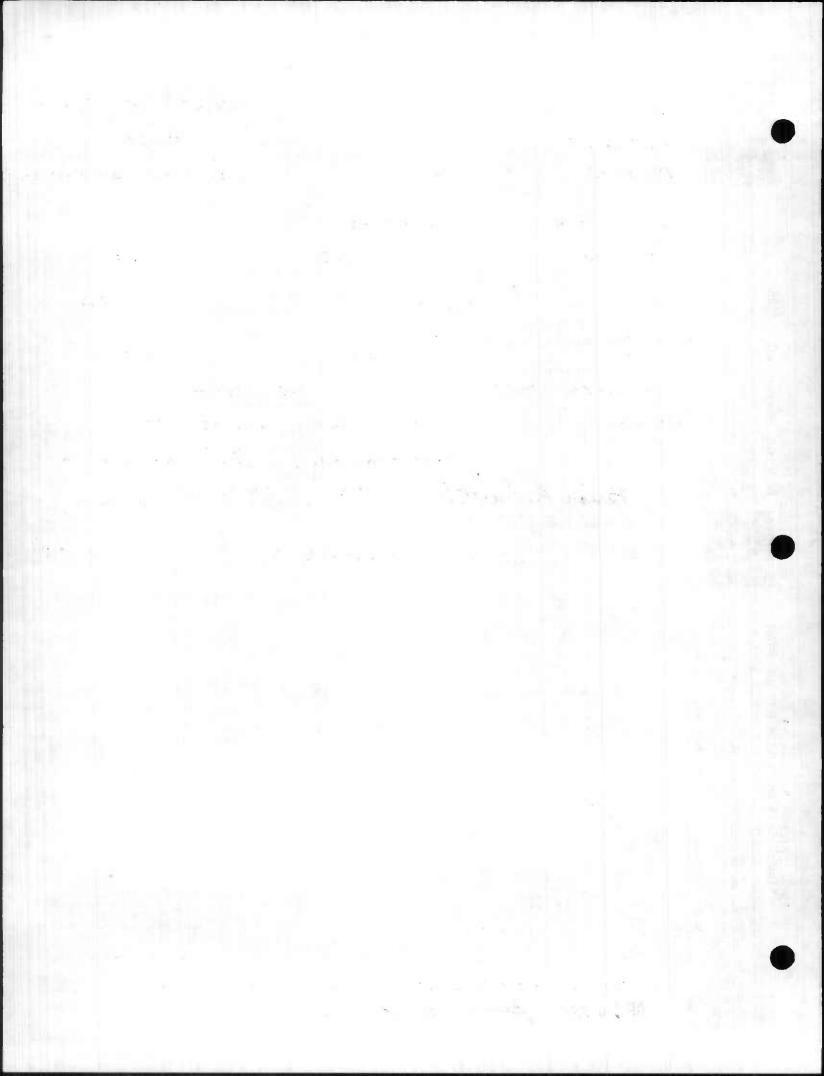
220-03-7700 Maryland 21-Apr-19 Mount Savage Allegany Maryland 12317 Woodcock Hollow Road, N.W. U.S.A. White Homemoker Homemaker 12 Elizabeth Meyers George A. Bridges 12317 Woodcock Hollow Road Mount Savage Maryland 21545-William A. Moore Husband

Durst Funeral Home, 57 frost Ave., Frostburg, MD 21532

Frostburg Memorial Park 01-Mar-99 Frostburg, Maryland

# Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 09247

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State of Maryland / Department of Health and Mental Hygiene 9 9 9 2 4 8

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pletely filled in by the funeral director, page 2 should be detached for use as the bur edical Certification: To Be Completed by Physician/Medical	Immediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to incause. Enter Undiceuse (Disease or that initiated event resulting in death)  Part II. Other significant in the sequence of the sammer?  1 Yes 2  27. Manner of Deat 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	rred to medical  No th 5   Pending investigat 6   Could not determine  1   Certifying 2   Medical Ex	a. Co.  b	Due to (or a Due t	as a consequence as a c	uence of):  uence	ven in Part I.  26. Piace of De her: 4 \( \text{Nursing 1} \) yes 2 \( \text{No} \)  ime, dete and piacoplnion, deeth occoplnion, deeth occording to the complete occoplosion of the complete occoplosion.	23b. Did 1 24a. Wes perfo  ath (Check only of the control of the c	tobacco use co Yes 2 No en eutopsy rmed?  Yes 2 No one) dence 6 Oth how injury occur Street and Numb vn, Stete)  cause (s) end me date and place,	ntribute to 3 Pro 24b. W ave of 1[	Approximate interval Between Onset and Death Death Onset and D
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Certificate of Death

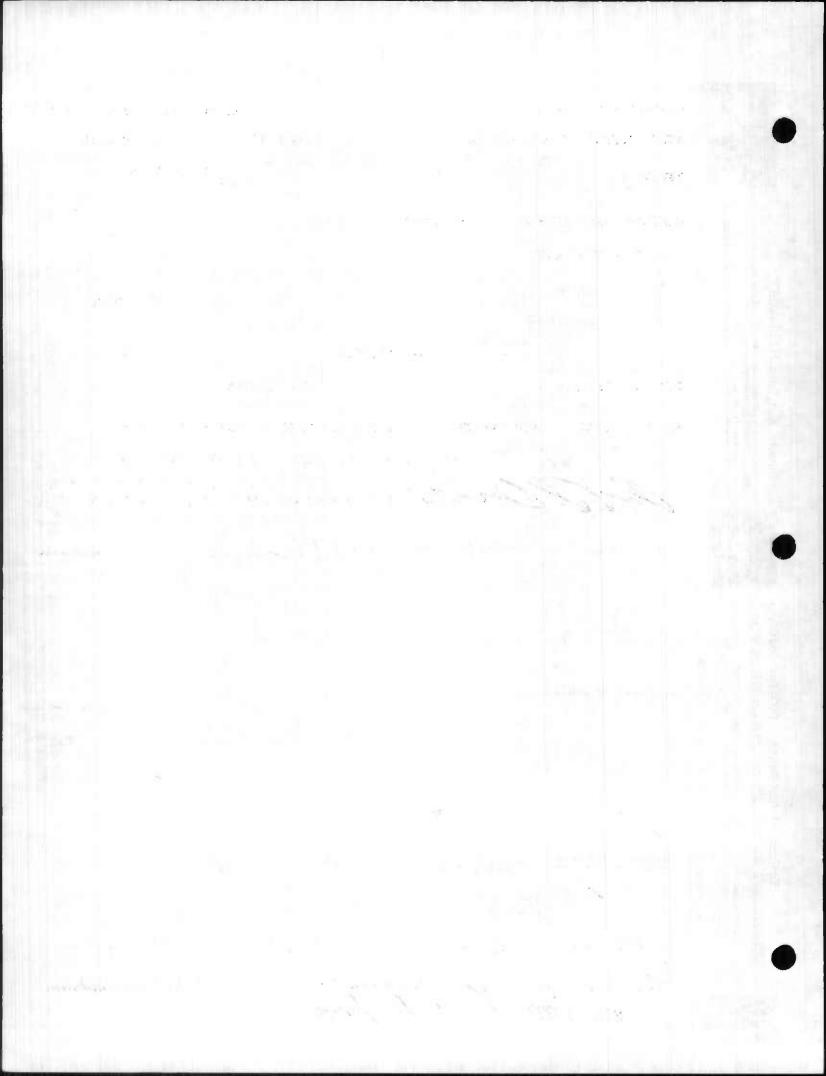
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	Funeral		5. Social Security Number 6. Sa	7ALABAMA 7. Age (In yrs. Ia:	st birthday) If Unda	r 1 Year   If Under 24 Hr		Wice	9 Birthole	aca (State or Foreign
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ar	2 should and is ma		19a. informent's Name/Ratationship (T	rpe, Print)	19b. Mailing Addres	s (Straet end Number or F	iural Routa Numbe	r, City or Town,	Steta, Zip	20da) 21801
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ore	of He		20a. Mathod of Disposition	20b. Ple	ce of Disposition (Na natary, cramatory or	ma of other place)	Date	20c. Location -	City or Tow	vn, Stata
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<u>&gt;</u>	or A free in by	Certification:	4 ☐ Homicida datarminad	28a. Plece of Injury - At hom building, atc. (Specify)	e, ram, straat, racto	у, опіса	28f. Location (Si City or Town		r or Hurai	House Number,
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	To the Hospital or Attending Ph within 2 Hours after death. To the Funeral Director After th completely filled in by the funeral		one)	and mannar stated.						
	To To	Σ	29b. Signature and title of certifier		29	c. Licansa number	2	9d. Data signed	(Month, D	ay, Year)
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State of Maryland / Department of Health and Mental Hygiene Q

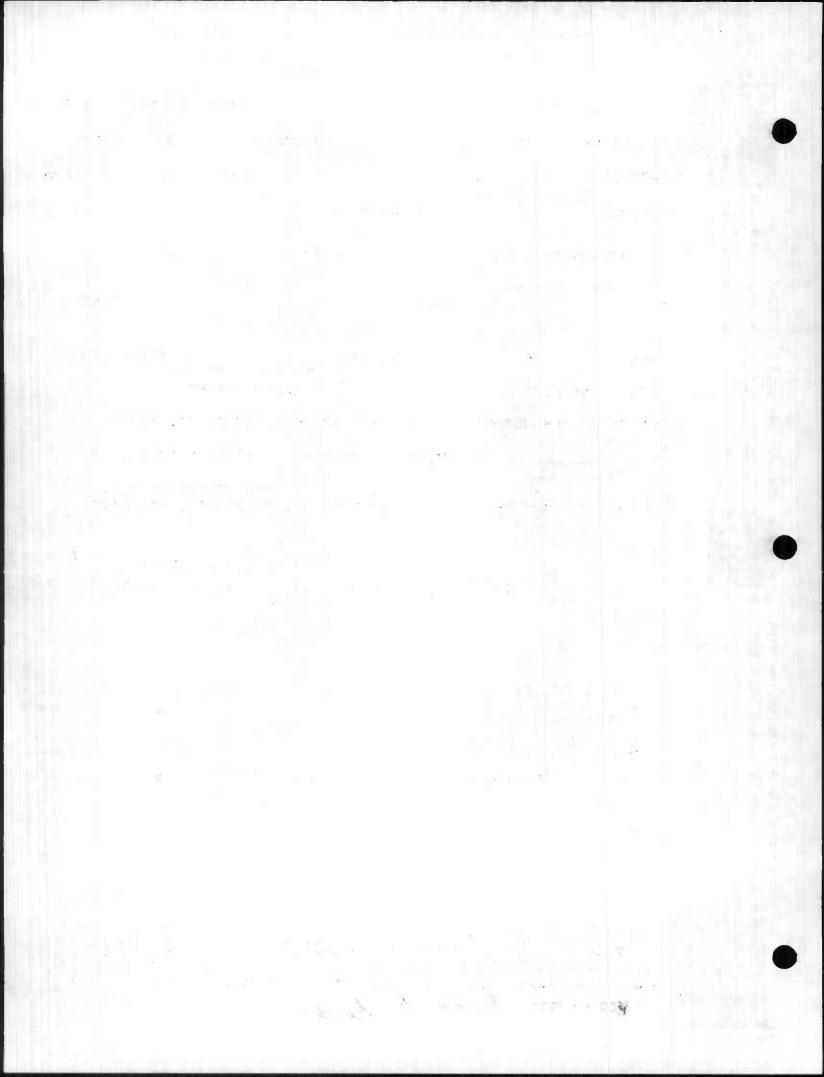
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 3:40 AM Christine Blythe Myers 1999 March · /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** 1□M 2 F 51 Yrs. MARYLAND **Director** 214509 471 Usual Residence of Decedent JULY with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at 1 No Yes 2 No Directo MARYLAND ANNE ARUNDEL ANNAPOLIS 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 8 SOUTH MONROE ROAD 21401 UNITED STATES Peges 1 end 2 should be filed within 72 hours efter death vent of Health and Mental Hygiene. At: If them 27 is marked other then "natural", or thems 23 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No It Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lt Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Meritel Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) STATISTICIAN COMPUTER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) JOHN CHARLES MYERS ANN BLYTHE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) other t JAMES T. LONG STEP FATHER) 12319 COOPERS LANE WARTON, MD. 21678 20c. Location - City or Town, State 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition permit. Peges Depertment of Important: If it any Injury or o 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from State FT. LINCOLN CREMATORY 03-12-99 BRENTWOOD, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility JOHN M. TAYLOR FUNERAL HOME, INC 147 DUKE OF GLOUCESTER ST. ANNAPOLIS, MD. 21401 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Redal Carcinama Immediete Ceuse (Final diseese or condition resulting in deeth) /Medical 4- known **Examiner** Due to (or es e consequence ot) Examiner certificate be executed physician and s the buriel-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequença of) P.O. Box 68760 Physician/Medicai Due to (or as e consequence of) 88 esn ed by the a 23b. Did tobecco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert f. 1 Yes 2 No 3 Probably 4 → Unknown signed t Division of Vital Records. Aq 24b. Were autopsy tindings aveilable prior to completion of cause of deeth? 24e. Was an autopsy performed? Completed hes page 2 No certificate or Attending Physician: efter death. Director: After this certifica 25. Wes case reterred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 2₽ER/Outpatient 3□ DOA 10 1 Inpetient funerai 27, Menner of Deeth 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify) 24 hours Hospital 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and menner stated. To the To the To the F 29b. Signeture and title of cartiful 29c. License number 29d. Dete signed (Month, Dey, Year) 037064 same and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Mas 21666 Dr James Chamberlain Steverswille, (30 31. Date tiled (Month, Day, Yeer) MAR 1 2 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deeth Dey 1999 MARCH 6 **Physician** 4:45 am GEORGE H. MANION /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner ANNE ARUNDEL MILLENNIUM AT SOUTH RIVER EDGEWATER If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 15M 20 F Yes Director 218-32-8804 76 APRIL 20 1922 MARYLAND Usuel Residence of Decedent with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Modical Examiner must be notified at FRIENDSHIP 1 Yes 2 No MARYLAND Director 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 223 FRIENDSHIP ROAD 20758 US Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by BLACK 3 ₩ Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) SELF EMPLOYED FARMER 6th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked orth any injury or other treumstic event BDCS. ALICE STARKS DENNIS MAYNARD 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) P.O. BOX 181 CHURCHTON, MD. 20733 LEROY CREEK (GRANDSON) 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1X Burlel 2 ☐ Cremetion 3 ☐ Removel from State UNION UM CEMETERY 3/11/99 LOTHIAN, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licenses 22. Name end Address of Fecility WM. REESE & SONS MORTUARY, P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errespications, or heart the mode of dying, such as cardiac or respiretory errespinatory. 10000 ANNAPOLIS, MD. 21401 Approximate Intervei Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) 3 months Examiner Examiner attending physician and for use as the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest certificeta be axecu Box 68760, Physician/Medical Due to (or es e consequenca of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 2 No 3 Probably 4 Unknown 1 Yea Anemia Division of Vital Records, by 8 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? no thymoidism 24e. Wes en eutopsy performed? Completed certificate has LIVES 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: 5 Pending Investigation or Attending 1 DNaturel 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end menner as stated.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pieca, end due to the ceuse(s) and menner steted. 29e. Certifier Medicai (Check only one) To the I within 2 To the 8 29b. Signeture and title of cartified 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name end address of person who, completed cause of death (Item 23e) (Type, Print) · Millersville, Md. 8601 hampers Veterans, Registrar



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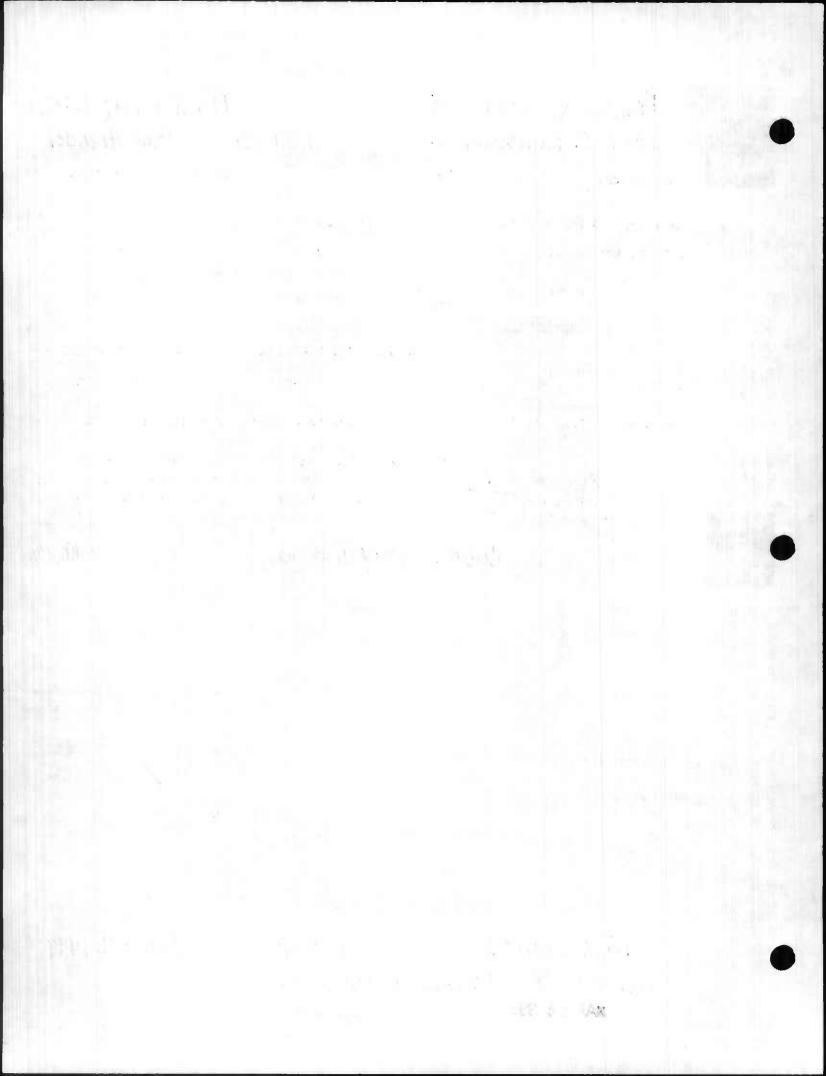
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Physician /Medical Examiner		HEL	ENG. 1	ncG	OWA	N		Month MARCH	Day	Year 1999	1:45 PM
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ınerai	7	Charlestown Care 5. Social Security Number 6. S	ex 7. Age (	In yrs. lest		der 1 Yea		8. Date of Birth		1timor 9. Birthole	
Director		0,0 ,0 0000	□M 2∏ F	86	Yrs. Mont	hs Day	s Hours Min.	NOV. 7,	1912		ce (State or Foreign y) CHUSETTS
natural, or items 23e or 28e-1 show attail Examiner must be notified at steed by Funeral Director		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, T	own or Location					100	J. Inside City Limits
	Ö	Maryland Balti	more		Catonsv	ille					1☐ Yes 2☐No
	al Direc	10e. Street end Number 707 Maiden Choic		. 7 <u>61</u>	1	Zip Code	21228	1	0g. Citizen of	What Country U.S.A	
Examiner in	2	11. Maritel Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Tyes 2 No If Yes, Give Yeer or Dates:	er in U,S.		ecedent of specify Cu s 2 No	f Hispanic Origin? (Suban, Mexicen, Puerlo o Specify:	pecify Yes or No- o Ricen, etc.)		ce - Americer ck, White, et y: Whi	c.
than "natural",	Completed	15. Decedent's Ec (Specify only highest gra Elementery/Secondary (0-12)	lucetion de completed) College (1-4or 5+)	10	6a. Decedent's U (Give kind of life. DO NO	Isual Occ work don Tuse retir	upation te during most of wor red)	king	16b. Kind of B		stry
4	o n	12			Secret	ary			Aircr	afts	
Be very		<ol> <li>Father's Name (First, Middle, Last)</li> <li>James</li> </ol>		loste	r		18. Mother's Nar	ne <i>(First, Middle, I</i> eene	Meiden Sumen	ne) Sulli	van
meti	0	19a. Informent's Name/Relationship (				ARE /C+			City or Tan-		
S 6		Donna DiGennaro	(Daughter				etend Numberor Au an Court,				•
mportant: If Item 27 any Injury or other to	-	20a. Method of Disposition  1XXBurial 2 □ Cremation 3 □	Removal from State	20b. Place ceme	of Disposition (interp., cremetory of Jerome	Neme of or other pi	lece)	Date	20c. Location	City or Town	n, State
mportant: If I any Injury or ance.	-	4 □ Donetion 5 □ Other (Specification 21. Signature of Fune at Service Licenters)		St.	Gerome						achusetts
any ir		· ()	Sul				Avenue,				
ician		23a. Part1. Enter the desise, or com- shock, or teart calling that only	plications thet caused the one ceuse <i>on</i> each line.	e death. D	o not enter the n	node of dy	ying, such es cerdied	or respiratory error	est,	i Ir	pproximete hterval Between Inset and Death
dical niner	ı	Immediate Cause (Final disease or condition		Str	olse						MONTHS
		resulting in death)	Du	e to (or as	a consequence	of):					
nsit	ledical Examiner		b. —							.	
		Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	Du	Due to (or es e consequence of):							
a as the bu		Cause (Disease or Injury that initiated events resulting in death) Lest  Due to (or es e consequence of):					-		1		
		d									
atached for us	ysic	Part II. Other significent conditions co	entributing to death but n	ot resulting	in the underlyin	g ceuse g	given in Pert I.	23b. Dld to	bacco use co	ntributa to ti	ne cause of death?
d be data		ANEMIA						1 🗆 Y	s 2⊠No	3 Probal	bly 4 Linknown
completely filled in by the funeral director, page 2 should be Medical Certification: To Be Completed b	אופופת ו							24e. Was a perforr	n autopsy ned?	avalia	autopsy findings able prior to eletion of ceuse ath?
								1□ Ye	s 20 No		′es 2□ No
		25. Was cese referred to medical					26. Plece of Dea	th (Check only on			
		exeminer? 1 Yes 2 No	Hospital:	2 ER/	Outpatient 3	DOA O		ome 5 Reside	-	er (Specify)	
		27. Manner of Death 1 ⊠Naturel 5 □ Pending	28e. Date of Injury (Month, Dey Ye		. Time of Injury	28c. Inje		28d. Describe ho			
		2 ☐ Accident Investigation	M 1 Yes 2 No			28f. Location (Street and Number or Rural Route Number, City or Town, Stete)					
Certific		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			9						
pletely filled edical Ce		29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	sician: To the best of m lnar: On the basis of exa end manner steted	aminetion a	ge, death occurre and/or investigati	ed at the ton, in my	time, dete and place, opinion, death occur	end due to the carred at the time, de	use(s) end ma ete end place,	inner as state and due to th	ed. e ceuse(s)
Med		29b. Signeture and little of certifier	1.1	Λ	2		nse number	25	9d. Date signe	d (Month, De	y, Year)
3		> Value,	+ my	rsh	no	D 2	26473		MARC	+ 5,	1999
	3	BERIVARD F	ompleted cause of deeth		(Type, Print)	1 17	AIOEN	CHOIC	E LA	NE	21278
State	3	31. Date filed (Month, Dey, Year)	32. Registrar's	Signeture	4	lac	11				

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 9 09253

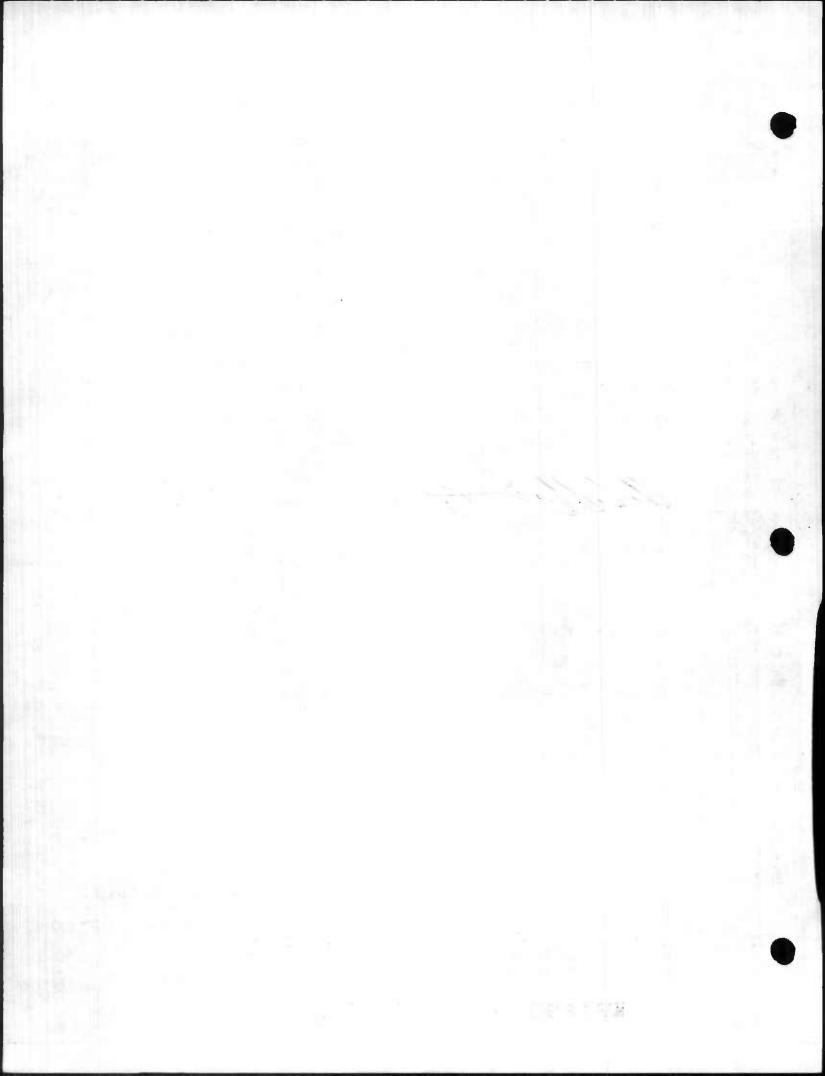
			Ce	ertificate of	Death	Re	eg. No.			
Physician /Medical	1. Decedent's Neme (First, Middle, La FYQNCIS X.	Maggent	+i			2. Dete of Deet	h Dey 1	999	3. Time of Deeth  12:30 AM	
Examiner	4e Fecility Name (If not institution, given 7387 S. DU	inrobbin C		M Deday 1 Va	4b. City, Town, or L Hanov	er	Anne	An	undel	
Funeral Director	5. Sociel Security Number 6. S 220-50-8231 Usuel Residence of Decedent	7. Age (In yrs	s. lest birthday Yrs.	Months Deys		8. Date of Birth (Month, Dey, MAY 21,		9. Birthpl Count MARY	eca (Stete or Foreign lry) LAND	
28a-f show sottlind at ector	10a. Stete 10b. County  MARYLAND ANNE AR		City, Town or L	ocation HANOVE	R			10	od. Inside City Limits 1 ☐ Yes 2 ☒ No	
5 8 0	10e. Street end Number 7387 S. DUNROBBIN	COURT		10f. Zip Code	21076	1	Og. Citizen of V	What Count	try?	
ar, or	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever In Armed Forces?  1 XYes 2 No 1 Side Yeer or Dates: 1 Side Yeer Or		. Wes Decedent of If Yes, specify Cul	Hispenic Orlgin? (Spen, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	Blac	14. Race - American Indien, Black, White, etc.  Specify: WHITE		
ed within 72 ho rgiene. we than "naturi t, the Medical Completed	15. Decedent's Ec (Specify only highest grades) Elementery/Secondery (0-12)		life.	edent's Usuel Occu e kind of work done DO NOT use retin IOR BELT		king	16b. Kind of Bu			
Mental Hyp inked other atic event, I To Be Co	17. Father's Neme (First, Middle, Last)	18. Mother's Nen ROSE	er's Neme (First, Middle, Meiden Surneme) SE (UNKNOWN)							
aith and M aith and M 27 is mar ir traumat	19e. Informent's Name/Relationship (	Type, Print) (SON)			BBIN COUR					
rages 1 sent of He int: If hem iny or othe	20e. Method of Disposition  1 ABuriel 2 Cremetion 3 4 Donetion 5 Other (Specific	Removel from Stete	cemetery, cri	cosition (Neme of emetory or other planets RANS CEME			20c. Location -			
Departmen Important any injury alse.	21. Signature of Kuneray Service Licer	he A	_	22. Name end Addr 1 SECOND	ess of Fecility S AVENUE, S					
Physician /Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death)	plications that caused the decone ceuse on each line.		Hery dis		or respiretory erro	est,	U	Approximate Intervel Between Onset and Death	
or certificate be associated individual physician and use as the burial-transit in/Medical Examiner.	Ceuse (Disease or injury that initieted events resulting in deeth) Lest	b	Due to (or es e consequence of):  Due to (or es e consequence of):							
y the atterched for	Part II. Other significant conditions of	ontributing to death but not re	iven in Pert I.	23b. Did tobacco use contribute to the cause o						
s been si 2 should pieted						24e. Wes e perfon	on eutopsy med?	eve cor of e	ere autopsy findings eilable prior to mpletion of cause death?	
this certificate ha ral director, page 3:	25. Was case referred to medical examples 2 No	Hospitel:	TED/Outral	2 POA 0	thor:	1 ☐ You the (Check only or lome 5 ☑ Reside	ne)		Yes 2 No	
Attending Physical Colors of the funeral dispersion: Ification: To	27. Manner of Deeth  1 Naturel 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Yeer)	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing					ner (Specif) rred		
S after sold in the second sold	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At building, etc. (Spec ysician: To the best of my kr	cify)			28f. Location (Si City or Town	n, Stete)			
within 24 hours To the Funer completely fill	(Check only 2 Medical Exam	ilner: On the best of my kr end menner stated.		nvestigation, in my		rred et the time, d		and due to	tha ceuse(s)	
<u>- ₹ - 8</u>	> Effect bu	ggd Mig	om 236) /Tu-	Da	28640	7000	Marc	h 4,	1999	
	30. Neme and address of werson who are silverson	to pleted cause of deeth (Ite	suille	, M)	21032	Jera	100	, and and		

Registrar



State of Maryland / Department of Health and Mental Hygiene 9 9 9 2 5 4

			Ce	rtificate of	f Death		Reg. No.	0360	13
	1. Decedent's Neme (First, Middla, Las	it)				2. Data of De Month	eath Dev	3. Time o	of Death
Physician /Medical	JAMES C. MACK	MARCH	Н 6, 1999 2:						
Examiner	4a Facility Nama (If not institution, give	street and number)			4b. City, Town,	or Location of Deat			
	ANNE ARUNDEL MED	ICAL CENTER			ANNAPOLI	S	ANNE A	RUNDEL	
Funeral Director	5. Social Security Number 6. Social Security Number 6. Social Security Number 1	ex. 7. Age (in yrs.	. last birthday) 80 Yrs.	Months Day		Irs. 8. Data of Bir (Month, De		9. Birthplaca (State Country) IRELAND	or Foreig
P .	Usual Rasidence of Decedent  10s. Stata 10b. County	10.0							
he death with the Maryla liters 23e or 28e4 should the must be notified at Tuneral Director	10a. Stata 10b. County  MARYLAND ANNE ARU		ity, Town or Lo					10d. Inside (	Sity Limits
with the Ma Libe notified I Director	10e. Street and Number  4A SPA CREEK LAND	TNC		10g. Citizen of V					
na 22 mas 22	11. Meritel Status	12. Was Decedent Evar in U	J.S. 13.	2 140 3 Was Decedent of		(Specify Yas or No	UNITED	e - American Indian,	
Fr. or	1 Nevar Married 2 Married	Armed Forcas? 1 [XYas 2 ☐ No If Yas, Giva Yaar or Datas:		If Yas, specify Cu 1 ☐ Yes 2 ☐XN	iban, Mexican, Pu	èrto Rican, etc.)	Blac	WHITE	
72 hz	15. Decedant's Ed (Specify only highest grad		16a. Dece	dent's Usual Occ	upation	wakina	16b. Kind of Bu	usiness/Industry	
ed within 72 ho yglene. wer then "naturn f. the Medical.	Elementary/Secondary (0-12)	Collega (1-4or 5+)	lifa.	DO NOT use reti	a during most of a red)	WORKING			
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Be sept	17. Fathar's Nama (First, Middla, Last)				18. Mothar's N	Nama (First, Middle	, Maiden Sumam	a)	
Men Men To To	SAMUEL MACK				SARAH	McALLIS	TER		
2 sh and lam mus	19a. Informant's Name/Relationship (7	**				Rural Route Numb			
도당하는	RUTH MACK (	WIFE)			LANDING	ANNAPO	LIS,MD.	21403	
samit. Pages 1 a Separtment of He mportsett: If them iny Injury or other abox.	20a. Mathod of Disposition 1 Burial 2 Tramation 3		Place of Dispo cematary, crai	osition (Nama of matory or other p	/ace)	Data	20c. Location -	City or Town, Stata	
Pages mart of land of art. If the ary or or	4 Donation 5 Other (Specify		LINC	OLN CREM	ATORY	03-07-99	BRENTWO	OD . MD .	
A Indian	21. Signatura of Funeral Service Atom	ige.	22	2. Name and Add	ress of Fecility				
a de la	1////	4	>					UNERAL HOL	
	11.00.13	7	1	47 DUKE	OF GLOUC	CESTER ST	. ANNAPO	LIS, MD. 2	
	23e. Pert1. Enlar tha disease, of composhock, or heart failura. List only of	dications that caused the daa	th. Do not en	tar tha mode of d	ying, such as card	fiac or raspiratory a	rrest,	Approxima Intarval Be	etween
Physician		_ /						Onset and	Death
/Medical	Immediata Causa (Final disaasa or condition	· Palmo	ma	y A	Wig	~		400	VC
Examiner	rasulting in death)	e. Dua to (	or as a conse	ouence of):				1/2010	
Je Je			2	7				r v	
death certificate be executed of attending physician and but for use as the but altransit sician/Medical Examiner	Sequentially list conditions	b. — Dua to (	or as a consec	nuence of):					
exec n an ial-tr	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury								
Sicia bur	Cause (Diseese or Injury that initiated evants	C							
ng physicia as the bui	rasulting in death) Last	Due to (d	or as a consec	quanca on:					
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at the death celd by the attendicetached for use									
res that the de signed by the si be detached by Physic	Part II. Other significant conditions co	ntributing to death but not ras	sulting in tha u	indarlying cause	given in Pert I.	23b. Dld	tobacco use cor	ntribute to the cause	of deati
d by detay						1 🗆	Yes 2 No	3 □ Probably	Unkno
by by						_			
The law requires that rate has been signed by page 2 should be determined.							an autopsy ormed?	24b. Were autopsy available prior	r to
has be						-		completion of of death?	cause
The late has page						10	Yas ak No	1 Yas 20	∃ No
certificate rector, pa	25. Was casa referred to medical				26 Place of I	Deeth (Check only	1		-
	axaminar?	Hospital:	1500		ther:			H 40 20 H 3	045
Physical distriction of the state of the sta	27. Manper of Death	1 Nopatient 2	28b. Tima o	NI 3LI DOA	4 LI Nursin	g Homa 5 Rasi	how injury occurr		
D 55 C	1 Naturel 5 Pending	(Month, Day Year)	Injury	W		200. Describe	now injury occur	90	
f or Attending after death. Director: After din by the fune	2 Accident invastigation 3 Suicide 6 Could not be			M 1	Yas 2 No				
at or Attendir s after death. M Director: Af ed in by the fu	4 Homicide datamined	28e. Pleca of Injury - At h building, atc. (Speci		reel, factory, offic	0	28f. Location ( City or To	Street and Numb wn, Stata)	er or Rurel Routa Nu	mber,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert									
To the Hospital within 24 hours a To the Funeral completely filled Medical Ce	29e. Cartifiar Certifying Phy	valcian: To the best of my kno	owiedge, deati	h occurred at tha	tima, date end pla	aca, and dua to tha	cause(s) and ma	innar as stated.	
he Hospi in 24 hou he Funer pletely fill edical	one) 2 Medical Exam	Iner: On the basis of examine and manner stated.	ation and/or in	vestigetion, in my	opinion, death of	ccurred at the time,	date and piece,	and dua to the cause	(s)
Within To the Comp	29b. Signature and titla of certifiar	1.1		29c Lice	nse number		29d. Date signe	d (Month, Day, Year)	
- 3 - 0	\$ \$1.77 \$	18ste-		Di	2670	13	3/6	190	
	.6	o cont		7	0 / 7		10		
	30. Nama and addrass of person who c	omplated causa of death (Iter	m 23a) (Type,	Print)		205 Ri	lgoly	Ave	
	MONARY D.	GO L D ST	Em	1 100	-11 - 1	Anna	pol65	md. 2	140
State	31. Dete filed (Month Day, Year)	32. Registrar's Signa	atura	1	34.71				
Pogietrar	CI O II /I/III	33	7						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Amend. 9 3/10/99 Sm AACO Health Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** George Leo McGurn March 06, 1999 1:00 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) **Examiner** Annapolis
r If Under 24 Hrs.
Hours Min. Anne Arundel Genesis Elder Care Spa Creek If Under 1 Year 8. Defe of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Days Yrs Director 213-48-3441 99 July 07, 1899 Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 77 is marked other than "natural", or items 23s or 25s-f show treumstic event, the Medical Examiner must be notified at 1♥ Yes 2 No Maryland Anne Arundel Directo Sherwood Forest 10e. Street and Number 10f. Zip Code 10g. Citizen of Whaf Country? 21405 United States 812 Robin Hood Hill Funeral deeth Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedenf of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status pemit. Pages 1 end 2 should be filed within 72 hours effer to Department of Health end Mental Hygiena. Important: If item 27 is marked other than "natural", or iten any injury or other freumatic event, the Medical Example 2059. 1 Types 2 No ff Yes, Give Year or Dates: 1 Never Merried 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 5+ U.S. Government Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) To Thomas Patrick McGurn Catherine Gallagher 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Thomas Peyton McGurn (Son) 812 Robin Hood Hill Sherwood Forest, MD 21405 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 3/8/99 Brentwood, Maryland Lincoln Crematory 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complicate shock, or heart feilure. List only one that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, Approximete Intervel Between Onset and Death Physician Prostate Cancer /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Heart Block S/P Pacemaker Examiner attending physician and for use as the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last certificate be axec Physician/Medical P.0. 23b. Did tobacco use contribute to the cause of death? Pert fl. Other significent conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings evalleble prior to completion of cause of death? 24a. Wes en autopsy periomed? Completed cartificate has 1 Yes WINO 1 Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? Certification: 1 X Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident of the death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - Af home, farm, sfreef, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, end due to the cause(s) end menner es stated.

To the Hospital within 24 hours e To the Funeral C complately

> State Registrar

Medical

(Check only one)

29b. Signature and Mue of certifier

MAR 0 8 1999

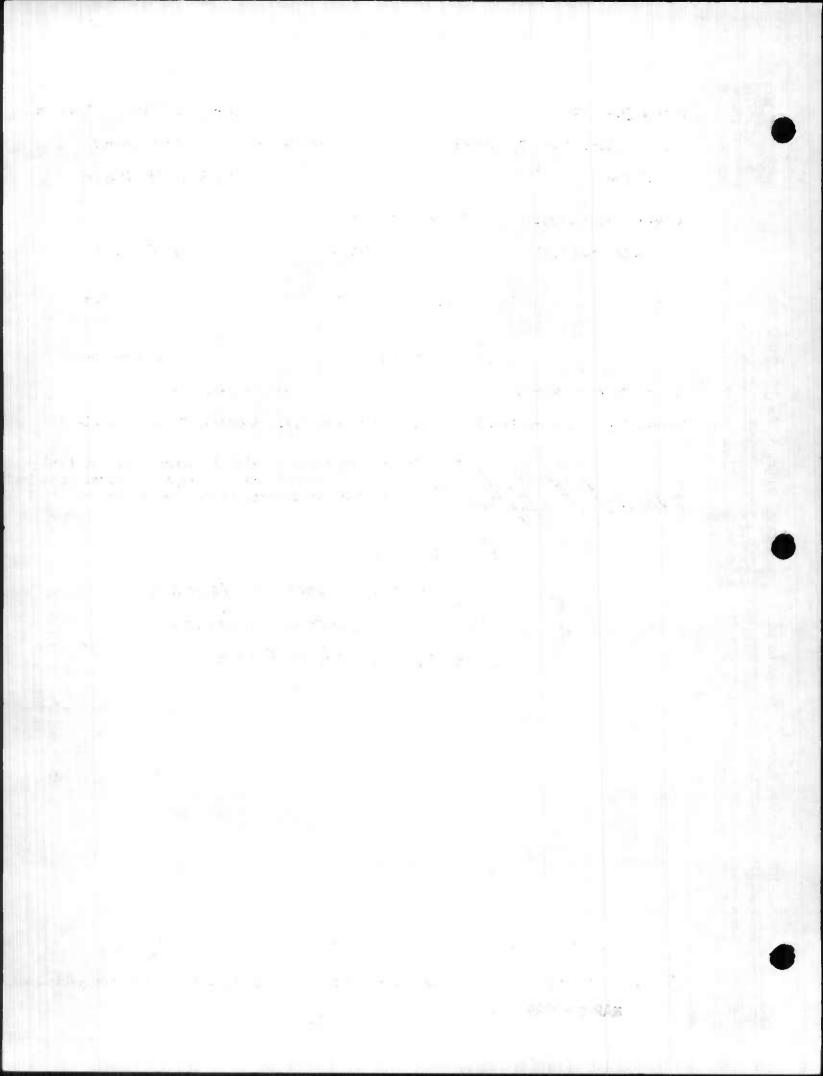
GONDON MO 32. Regisfrar's Signature

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

2003 Medical Parkway Suite 100 Annapolis, MD

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) end manner stated.

29d. Dete signed (Month, Day, Year)



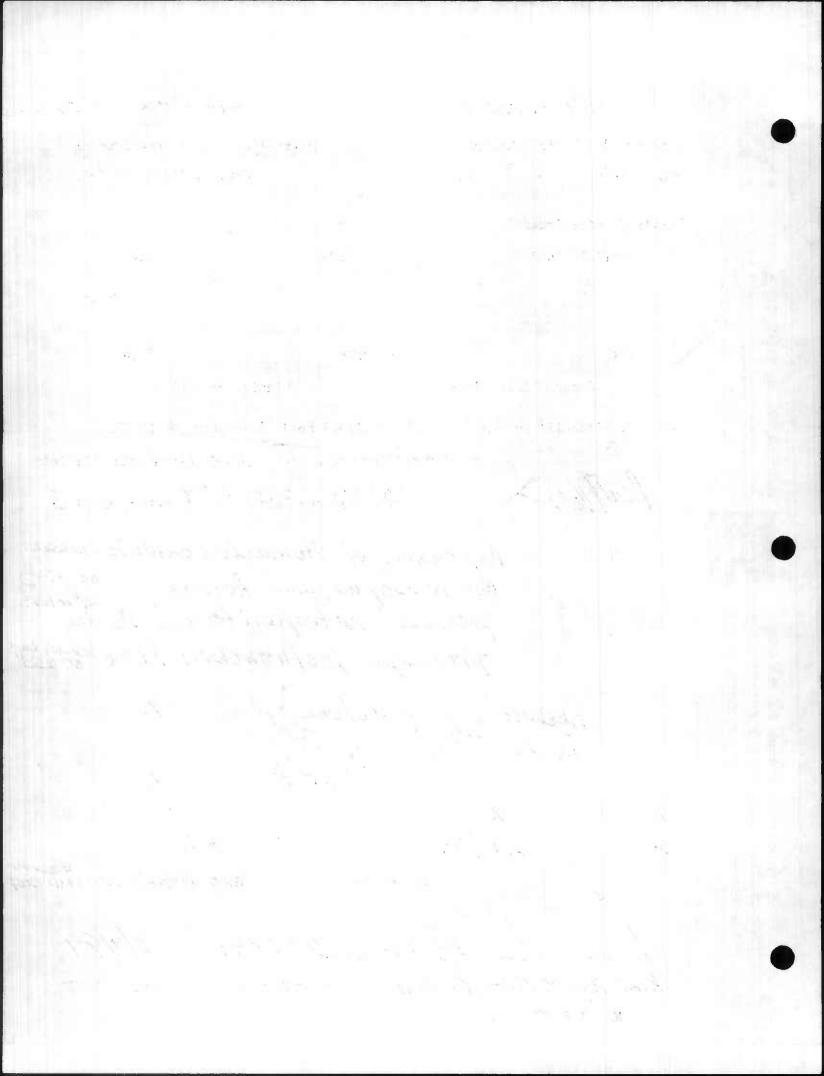
State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Physician March 3, 1999 Minnie S. Mitchell 8:06 P.M. /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Annapolis
If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Min. (Month, Day, Year) Anne Arundel Medical Center Anne Arundel If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 ☐ M 2 🗓 F 7. Age (In yrs. last birthday) **Funeral** Days Yrs. Director 228-24-0698 Jan. 1, 1926 Virginia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturef", or items 23a or 28a-f shov traumstic event, in a Medical Exameter must be notified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1500 Warfield Road 21037 USA Funerai 12. Wes Decedent Ever in U,S. Armed Forceş? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 2 should be filed within 72 hours after n and Mental Hygiene. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) James Phillip Shaw Minnie Lee Butler portain. Pages 1 and 2 sh.
Department of Health and h.
Important: if item 27 is markent july or other.
any injury or other. 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James P. Mitchell/ Husband 1500 Warfield Road Edgewater, MD 21037
Date 20c. Location - City or Town, Stete altimore, 20a. Method of Disposition
1 ☐ Burial 2XX Cremation 3 ☐ Removal trom State 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 3/6/99 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Pd Fig Solomons Island Rd. Edgewater, MD 21037 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. **Physician** Stomach confents immediate /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examine sician and bunal-transit Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician Physician/Medicai the general day ombia 88 use for Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I 23b. Did tobacco use contributa to the ceues of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only one) examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 27. Manner of Deeth 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how Injury occurred After or Attending 5 Pending 1 Natural 24 hours after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) filled in by 4 Homicide hom 1500 warfield Road MD 21037 Hospital 29a. Certifier 🐹 Cartifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner as steted. Medical 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) within 2 To the 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier 29c. License number 30. Name and eddress of person with completed gause of death (Item 23a) (Type, Print)

Kaki Algero Vitz-Bickell 1 134 Owensville Rd. West River, MD 20778 31. Dete tiled (Month, Day, Year)

State Registrar

MAR 0 8 1999

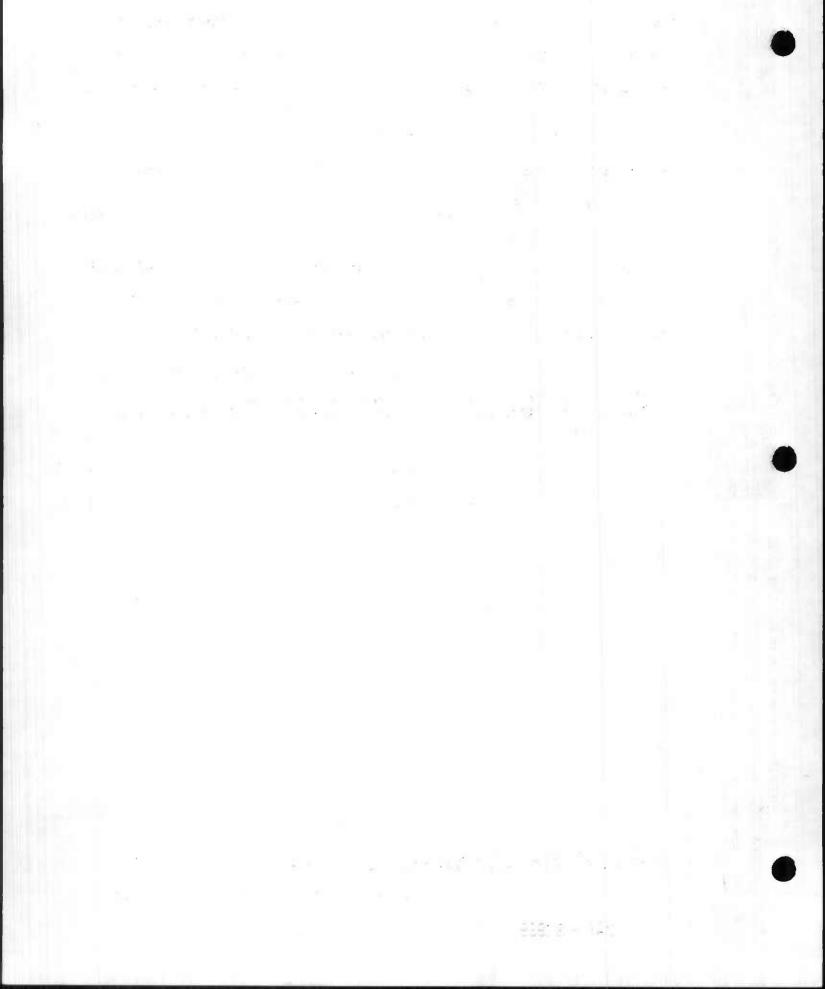
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nema (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Dev Yaai **Physician** February 28, 1999 Wayne Allen Moyer, Sr. 5:15 PM /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, giva street and number) 4c. County of Deeth Examiner 438 Bray School Road 0akland Garrett If Under 24 Hrs. Hours Min. If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Deys Yrs. 218-36-6380 56 **Director** Jan. 19, 1943 Maryland Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mentel Hygiens. Innocrant: If them 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other traumatic event, its Medical 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Garrett 0akland 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 438 Bray School Road 21550 USA Funeral 12. Wes Decedent Ever In U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Yeer or Dates: 1961–65 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-lt Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 ☐ Naver Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify 3 Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 12 Boilermaker Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be Pliny Moyer Mary \_\_\_\_ Hoyle 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Intormant's Name/Reletionship (Type, Print) 21550 Tena S. Moyer/Wife 438 Bray School Road, Oakland, MD 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removel trom State 4 ☐ Donetion 5 ☐ Other (Specify) Bray Cemetery 3/3/99 Oakland, MD 22. Name end Address of Facility 21. Signeture of Funeral Service Licenses Stewart Funeral Home 32 S. Second St., Oakland, MD 23e. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final Months diseese or condition resulting in deeth) Colon Carcinoma Examiner Dua to (or es e consequence of): Examiner Months Metastasis to Liver physician end s the buriel-transit The lew requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence ot): 88 USB 23b. Did tobacco usa contribute to the cause of death? been signed by the s should be detached Pert II, Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 X Unknown þ 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Wes en autopsy Completed s certificate has t 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funerel director, Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 ☒ No After this 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 1 Neturel 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigetion after death 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, tarm, streat, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 | Homicide 24 hours a Hospital 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifier H26154 3/2/99 30. Name and address of person who completed cause of deeth (item 23a) (Type, Print) 69 Wolf Acres Road, Oakland, Maryland Dr. P. Daniel Miller, DO 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State MAR - 8 1999 Registrar

DHMH 16 Rav 6/95



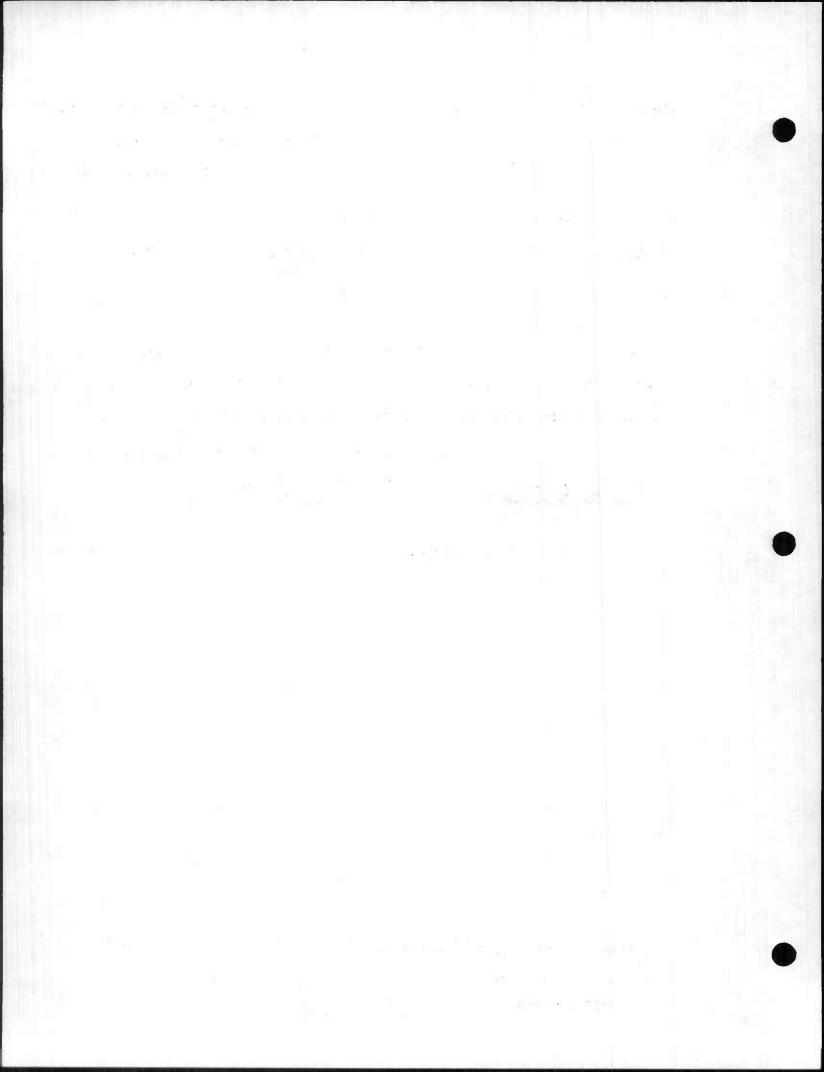
	Physici /Medi Examir	cal	Audrey  4a Facility Name (If r	Meloz		McHal	4b. City, Town, or	February 28, 1999 or Location of Death 4c. County of Death			2:00 PM			
	Exami		207 H St	reet					Mt. Lake	Park	Garr	ett		
	Funeral		5. Social Security Nur 215-26-23	111	Sex 7 1 □ M 2 💢 F	. Age (In yr.		hday) if Under 1 Yea Months Days		. (Month, De			ace (State or Foreign	
_	Director		Usual Residence of D			82				Dec. 2	9, 1916	New Y	ork	
	anylan	-	10a. State	10b. County		10c. C	City, Town	or Location				10	od. Inside City Limits 1 1 Yes 2 □ No	
	be filed within 72 hours after death with the Maryland stal Hyglene.  Ide the than "natural", or thems 23s or 28s-f show event, the Medical Examiner must be notified at	Director	MD 10e, Street and Numb	Garr	ett		M	t. Lake Par	rk		10g. Citizen of	What Coun		
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	ama 2	Funeral	11. Marital Status		12. Was Deced	es?	U,S.	13. Was Decedent of If Yes, spacify Cu	Hispanic Origin? (S	Specify Yes or No	- 14. Rad	ca - America ck, Whita, e		
70	or th	by Fu	1 ☐ Never Married 3 🕅 Widowed 4		1 Tes :	1 Yes 2 No If Yes, Give Yeer or Dates:					Specif	hite		
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Maryland 21215-0020	ithin 7 Ne.	Be Completed	Elementary/Second	dary (0-12)	college (1-	4or 5+)		(Give kind of work done life. DO NOT usa ratir		rking				
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lary	end M s mer		19a. Informant's Nam					Mailing Addrass (Street				, State, Zip	Code)	
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altimore,	permit. Peges 1 Depertment of H Important: if ites any injury or ott		20a. Method of Dispo 1 Burial 2 X 4 Donation 5	Cremation 3		tate	cameter	Disposition (Name of y, crematory or other pi Crematory		5/2/99		20c. Location - City or Town, State Morgantown, WV		
Dall	eperturborta		21. Signature of Fund	eral Service Lice	nsee	****		22, Name and Add Stewart I		ome				
_	005 4 0		Bio	Alber H:	Deval			32 S. Sec	ond St.	oakland	, MD 2	1550		
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	Examiner	10	resulting in death)		a			consaquance ot):						
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or vital Records, P.O. Box 68/	itclan: The law requires that the death certificate cartificate bas been signed by the attending physicator, page 2 should be detached for use as the	To Be Completed by Physician/Medical	25. Was casa raterra examiner?  1 Yes 2 Natural 2 Accident 3 Sulcide 4 Homicide	ant conditions of the medical of the miner of the medical of the miner of the medical of the miner of the medical of the medic	Hospital: 1 In In 28a. Date of (Month In Personal Place of buildin In 1981 claim : To the bui	patient 21 Injury, Day Year) of Injury - At g, etc. (Spec	esulting in ER/Ou 28b. Tir home, fa	tpatient 3 DOA Clime of W 1[cm, streat, factory, office, death occurred at the d/or investigation, in my	26. Placa of De wither: 4 \( \text{Nursing} \) ury at ork? \( \text{Yas} 2 \) \( \text{No} \)  time, date and place	24a. Was perfu	Yes 2 No s an autopsy ormed?  Yes 2 No one) Idence 6 □Ott how injury occu  (Street and Num wn, State)  causa(s) and m	3 Prob  24b. We ave condended to the con	pably 4 Unknown under autopsy tindings allabla prior to implation of cause deeth?  Yes 2 No  No  Route Number, lated.	

State Registrar

Dr. P. Daniel Miller, DO

31. Date filed (Month, Day, Year)

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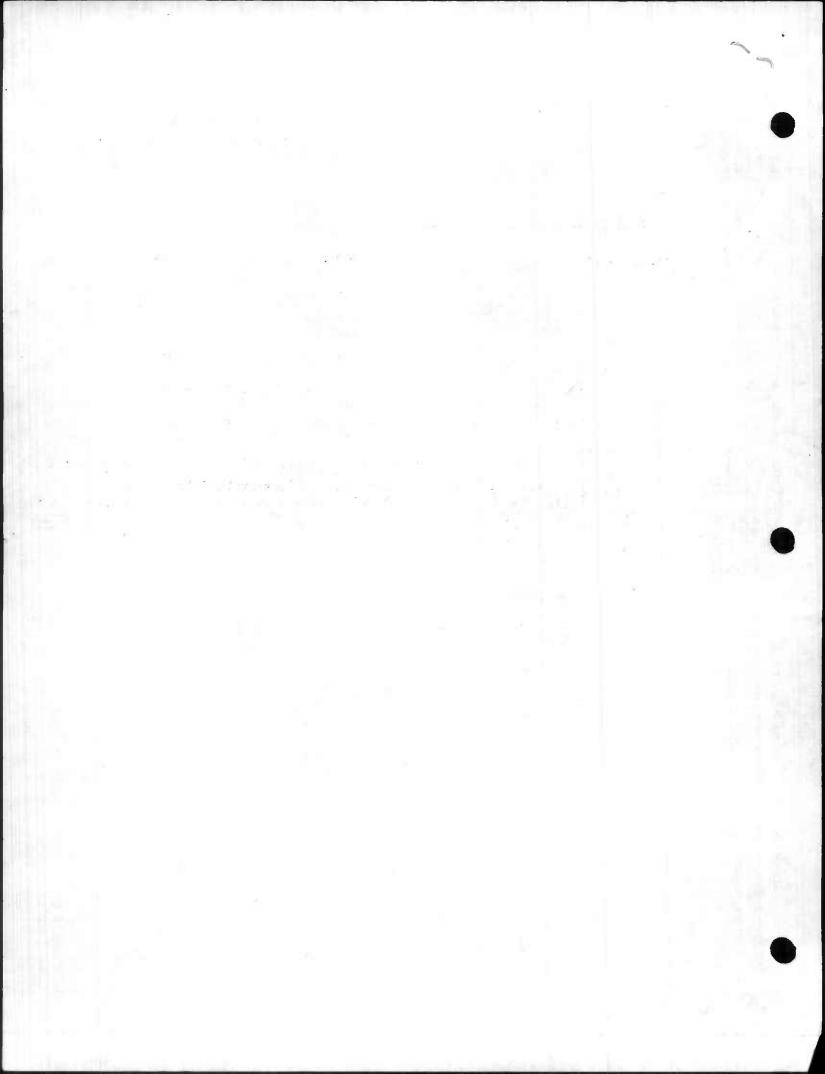
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #14,3/15/99,BMW,Montg.Co. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Francis Xavier Nagle 10,1999 March 4:38 PM /Medical 4e Facility Name (Il not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 M 2 □ F Yrs. 81 Director 577-12-7574 Nov. 20, 1917 Maryland Usual Residence of Decedent the Meryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "naturel", or items 23s or 28s-f show the Medical Examiner must be morrised at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2013 Serpentine death Funeral Terrace 20904 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Marital Status after Specify: WHITE 1 ☐ Never Merried 2 Married 1 XYes 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: p 3 Widowed 4 Divorced Whtie Yeer or Detes: WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed wit. Dependent of Health and Mental Hygiens important: if item 27 is marked other that any Injury or other traumatic event, that pales. Adjudicator Federal Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Francis I. Nagle Edith Pauline Stack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 2013 Serpentine Terrace Eileen Grace Nagle (wife) Silver Spring, Maryland 20e. Method of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) Deta 20c. Location - City or Town, Stete 1 ⊠Buriel 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 3/15/99 Silver Spring, Maryland gneral Se 21. Signature ø 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23e. Pert1. Emer the disease, or complication. If at caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest shock, or heart feilure. List only one cause in sech line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) a Pneumonia Examiner Dua to (or as a consequence of): b. Renal Failure physician and the buriel-transit certificate be asscuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Diabetes Mellitus Physician/Medical Due to (or as e consequence of): attending Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by I 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy peen page 2 1 Tyes 2K No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Wes case referred to medical Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2⊠ No Certification: To 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? is or Attending Faffer death.

I Director: After d in by the funer After 5 Pending investigation 1 Naturel 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28e. Plece of Injury - At homa, ferm, street, fectory, office building, atc. (Specify) 4 Homleida To the Hospital or within 24 hours aft To the Funerel Di completely filled in 10 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stelled. Medical 29a. Certifier 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of continue Tharley useur 204 D 26354 March 10, 1999 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 2021 Stanley Lugerner, M.D. Street, N.W. Washington, D.C. K 20006 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State MAR 12 32-second

**DHMH 16 Rev 6/95** 

Registrar

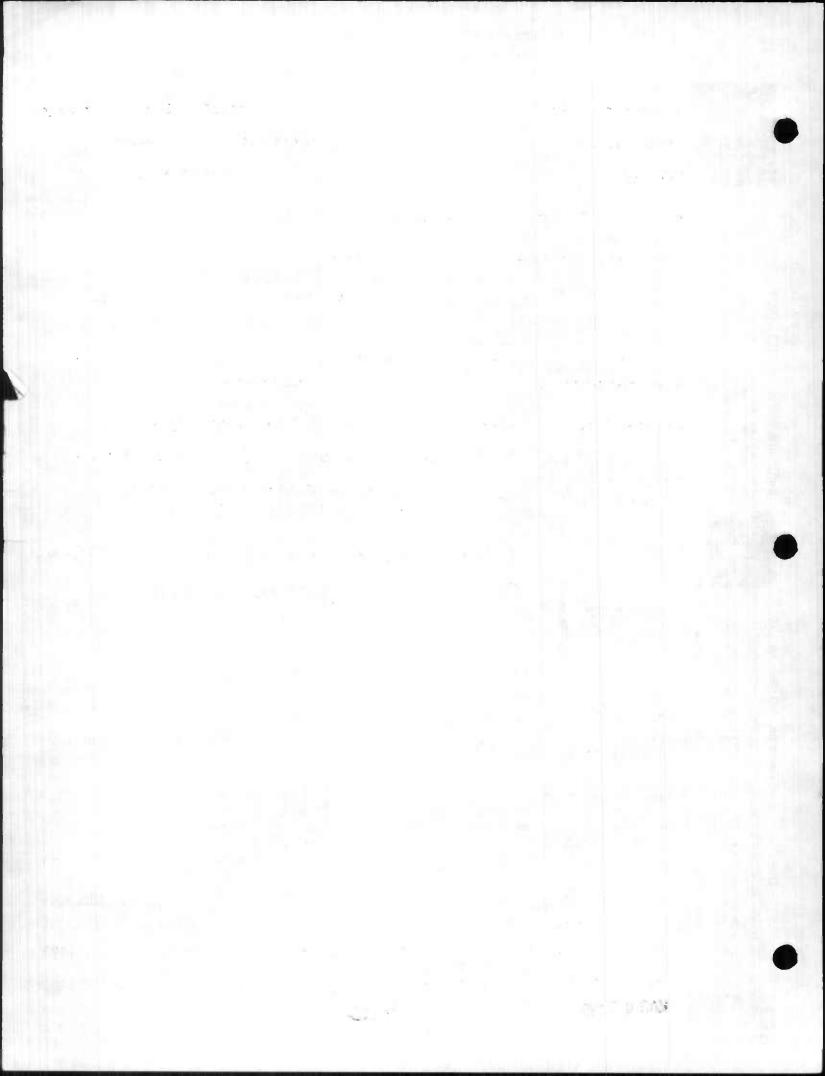


State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Hubert Gibson Nicol MARCH 1, 1999 3:05 pm /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Allegany Sacred Heart Hospital Cumberland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours Yrs. January 1 1925 Director 215-20-5174 74 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic avant, the Medical Examiner must be notified all 1 Yes 2 No MD Allegany Lonaconing Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 21539 USA 17303 New Memory Lane Pagas 1 and 2 should be filed within 72 hours after death vant of Haalih and Mantel Hygiana.

Hit: If Hem 27 is marked other than "natural, or items 23 mir; if her other traumatic avant, the Medical Example must my or other traumatic avant, the Medical Example must Funeral 12. Was Decedent Ever In U.S. Armed Forces? WIII 1 ⊠ Yes 2 □ No If Yes, Give US Army Year or Dates: US Army 14. Raca - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Paper 11 0 Carpenter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James Andrew Nicol Dolly Symons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 17303 New Memory Lane Lonaconing, MD 21539 Phyllis Nicol wife. 20a. Mathod of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State March 4 12 Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any injury or Laurel Hill Cemetery Moscow Mills, MD 4 ☐ Donetion 5 ☐ Other (Specify) 1999 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility & Mc Kengu Eichhorn-McKenzie Funeral Home P.A. 23a. Part i. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrast, MD 21539 shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner DIAC attanding physician and for usa as the burial-transit cartificata be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760, Physician/Medical Due to (or as e consequence of): 98 signed by the a P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 1 Yes 2 70 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findinga available prior to Completed 24a. Was an autopsy performed? DIENSIA completion of cause of death? paga 2 1 Yes 2 No 1 Yes 2 No cartificata of a transfer of the state of t funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 1 Yes 22 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 27. Mannar of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide Hospital 24 hours 16 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Cartifian completaly (Check only one) To the P within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of cartified 1999 MARCH 30. Name and address of person who completed causa of death (Itam 23a) (Type, Print) 902 Seton Drive, Cumberland, MD 21502 MRS We M.D. 32. Registrer's Signature State

**DHMH 16 Rev 6/95** 

Registrar



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Examiner	4e Fecility Name (If not ins	stitution, give	street and nu	mber)				4b. City, Town, o	or Location of Dea	th 4c. Count	y of Deeth	-	
	Memorial Hos							Cumber	1and	A11	egany		
uneral irector	5. Societ Security Number 214-07-0922	6. Se:	х ]м 2⊠ F	7. Age (In yrs. 84	last birthday Yrs.	Months	s Deys		in. 8. Dete of B (Month, L Oct. 2)	irth Day, Year) 5,1914	9. Birthple Country PA	ce (State or Foreigr y)	
	Usual Residence of Deced												
Important: If term 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Eventines mast be notified at once.  To Be Completed by Funeral Director	10e. Stete 10b. 0	County		10c. Ci	ty, Town or I	_ocation					100	d. Inside City Limits  1 ☐ Yes 2 No	
or 288-1 s be notified Director	PA Be	dford			Artem	as						TLI Yes Ze No	
ire line	10e. Street end Number					10f. 2	Zip Code			10g. Citizen of	Whet Country	y?	
ai	Rt.#1 Box 5	6					1721	1		US	SA		
Je le	11. Maritei Stetus		12. Was Dec	edent Ever in L	J,S. 13	. Was Dec	edent of	Hispanic Origin?	(Specify Yes or Nerto Rican, etc.)	lo- 14. Ra	ce - Americar		
by Funeral	1 Never Merried 25		1 Tes if Yes, Gi Year or D	2⊠No				Specify:	erto riioari, etc.,	Specia			
Be Completed	15. De	cedent's Edu	cation		16e. Dec	edent's Us	suei Occu	upation e during most of v	working	16b. Kind of E	Business/Indu	istry	
pie	Elementery/Secondary (	highest grad 0-12)	College (	1-4or 5+)	life.	DO NOT	use retir	ed)					
COL	8								emaker				
Se C	17. Fether's Neme (First, A	fiddle, Last)						18. Mother's N	leme (First, Midd				
To B	Edward Curi	cen						Annie	May	Sh:	ipley		
	19e. informent's Neme/Re	letionship (Ty	/pe, Print)		19b. Mei	ling Addre	ss (Stree	et and Number or	Rural Route Num	ber, City or Town	, State, Zip C	code)	
	Vernon North	raft	(Husl	nand)	Rt.	1 Bo	x 56	Artemas	, PA 172	11			
	20e. Method of Disposition		(Husi	20b.	Piece of Dis	position (N	lame of	land Comide	Dete	20c. Location	- City or Tow	m, Stete	
	1 Buriai 2 Crem	0e. Method of Disposition  1									glesmith, PA		
	21. Signeture Nuneral S			1 a				ress of Fecility	7,, , ,		, ,		
	+ Labert (	2. ad	ams	,		Merr 404	itt- Deca	Adams Fu tur St.	neral Ho Cumberla	and, Md.	21502		
an	23a. Pert1. Enter the dise shock, or heert failure	ese, or compi e. List only of	licetions thet one ceuse on e	caused the dee sech line.	th. Do not e						1	Approximete Intervel Between Onset end Deeth	
ai er	immediate Ceuse (Final disease or condition resulting in deeth)		e. PNEU	JMONIA							4	DAYS	
	, counting at deetil)			Due to (	or es a cons	equence o	ot):						
line			b. CARD	IOMYOPA	THY A	ND GE	ENERA	L DEBIL	LTY		10	YEARS	
in/Medical Examir	Sequentially list conditions	,		Due to (	or es e cons	equence o	ot):						
W T	Sequentially list conditions if eny, leeding to immediat cause. Enter Underlying Ceuse (Diseese or injury that initieted events	1	C										
dica	thet initieted events resulting in deeth) Lest			Due to (	or es a conse	equenca of	f):				1		
III/Medical Examiner			d.										
ian		_									i		
Sic	Pert il. Other aignificant c	onditiona cor	ntributing to d	eath but not res	sulting in the	underlying	g cause g	iven in Pert i.	23b. Di	d tobacco use c	ontribute to t	the cause of death	
y Physicia									1[	Yes 2/1 No	3 □ Probe	ably 4 Unknow	
Completed by									24e. We	es en eutopsy rformed?	com	re eutopsy tindings ileble prior to opletion of cause eath?	
Sm.									10	Yes 2 No		Yes 2□ No	
	OF Was soon referred to	nodica!						00 01 11			,,,	100 20 110	
Be	25. Wes case referred to n exeminer?		Hospitel: 📈		3.000			Wher:	Deeth (Check only				
To T	1 ☐ Yes 2 No 27. Menner of Deeth		1/2		ER/Outpati 28b. Time		DUA	4 U Nursin	g Home 5 ☐ Re	sidence 6 O			
ation	1 Neturei 5 🗆	Pending   28e. Date of In (Month, E		th, Day Year)	280. Time injury	M	28c. inj W	ork? ☐ Yes 2 ☐ No	26d. Describ	e now injury occu			
Certification:	3 ☐ Suicide 6 ☐	Could not be determined	28e. Piece build	of injury - At hing, etc. (Speci	nome, ferm, s	street, fect	ory, office	8	28f. Location City or 7	(Street and Num own, State)	ber or Rural	Route Number,	
mpletely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier Conf. Check only any	ertitying Plays edical Exami	ner: On the b	best of my kneasis of examination	owledge, dee etion end/or	eth occurre	ed et the on, in my	time, dete and pie opinion, death of	ece, end due to th ccurred et the tim	e ceuse(s) and n e, dete end plece	nanner es sta , end due to t	ted. the ceuse(s)	
Me Me	29b. Signature and title of	certifier		The same of the sa	- (	1 2	29c. Licer	nse number		29d. Dete sign	ed (Month, D	iay, Year)	

nes

Dr. Guy Fiscus, Memorial Hospital Medical Bldg., cumberland, MD 21502

31. Dete filed (Month, Day, Year) MAR 1 1 1999 State Registrar



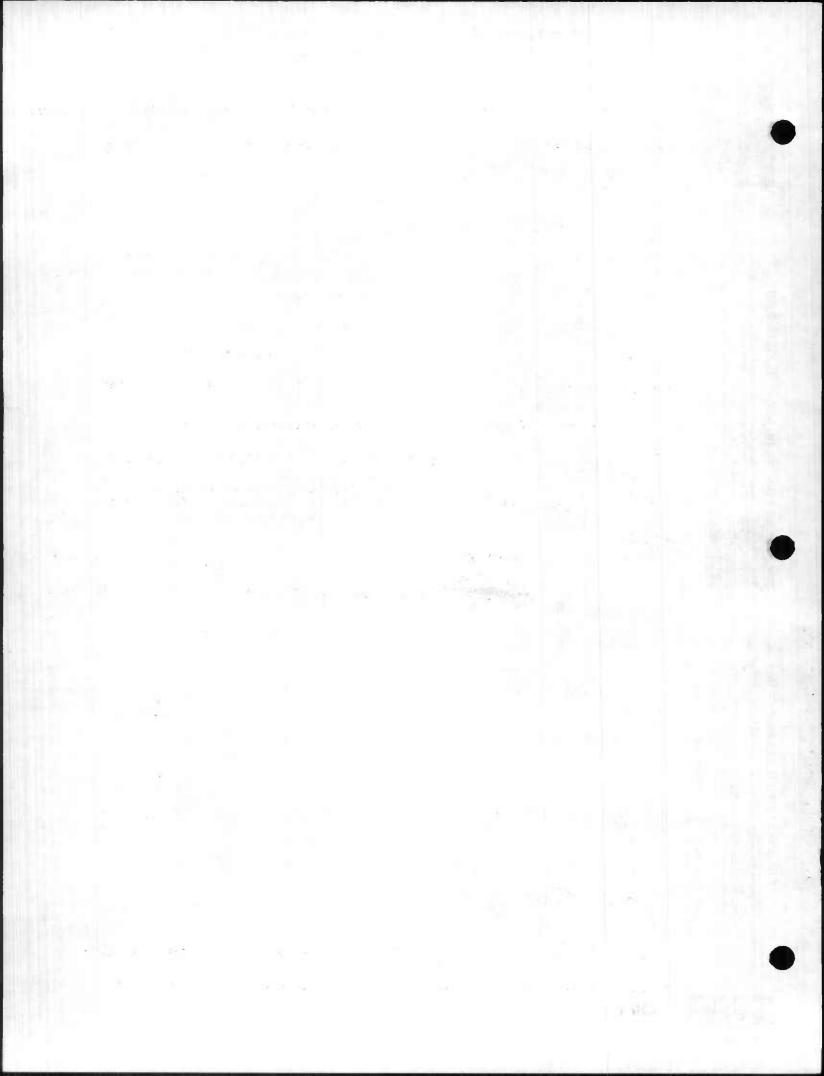
30. Name and address of person who completed cause of death (item Zoe) (Type, Pint)

D 12779

MARCH 11, 1999

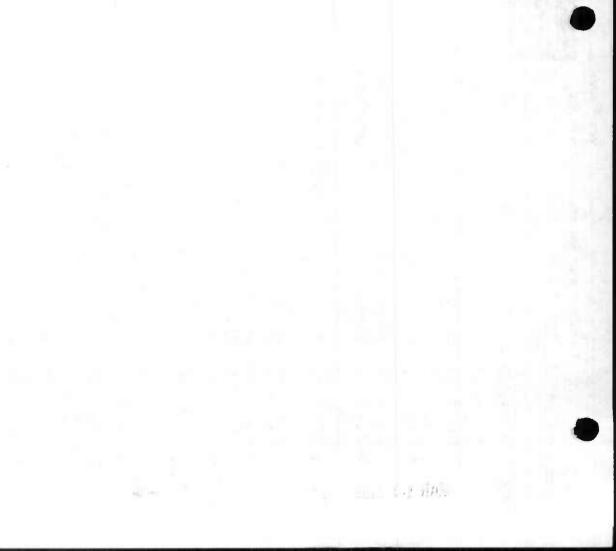
214-07-0922

BRIDGET NORTHCRAFT



	1. Deceden	t's Nama (First, A	Aiddle, Las	t)		001	tificate of	Dealir	2. Date of Deat			3. Time of Death
siclan edical	Mary	Margaret	t Nic	ol					March 8	, Day 199	99 <sup>Yaar</sup>	9:50 a.m
miner		Name (If not insti Nursing	_		mbar)			4b. City, Town, or I Lonaconin		4c. County Allega		
ral tor	217-6	curity Number		ax □ M 2 <b>X</b> F	7. Age (In ye	rs. lest birthdey) Yrs.	If Undar 1 Year Months Days			<sup>Year)</sup> 1917	9. Birthp Cour	elace (Stete or Foreig htry) WV
	10a. State	lence of Decadar 10b. Co			10c.	City, Town or Lo	cation				1	0d. Inside City Limits
Director	MD		egany		Lo	naconing	5,					1) Yas 2□N
Dire	10e. Street	ackson S	Streno	<b>+</b>			10f. Zip Code 21539			Og. Citizen of	What Cour	ntry?
by Funeral	11. Marital S		Married	12. Was Dec Armed Fo 1  Yes If Yes, Gir Year or D	orces? 2 K No ve	H	Vas Dacedent of	Hispanic Origin? (S an, Mexicen, Puert Specify:	pecify Yes or No-		ce - Amaric ck, White, v: Wh	
eted		15. Dece (Specify only hi	dent's Edi	ucation		16a. Deced	ent's Usual Occu	pation	rking	16b. Kind of B	usiness/in	dustry
Completed	Elamanta	ry/Secondary (0-		College (				during most of world)				
	17. Fathar's	12 Nama (First, Mio	idia, Last)		)	Homen	naker	18. Mother's Nan	ne (First, Middla, A	HOME Maiden Sumen	ne)	
To Be	Dora	Foltz							Triplett			
		ant's Name/Relat						end Number or Ru	rel Route Number			
	-	ta Prest	ion	daught		20603  Place of Dispos		e Road SW	- I			
	1 🕱 Bui	ial 2 Cramat				cemetary cram	Cemetery	7	arch 10	Lonacor		
	NO	a of Funeral Sen Omes E	mot			Ei	Nama and Addre		Funeral H	Home P.	0.	MD
iner	-	Causa (Final						Foclar				Onset and Death  I year  I year
In/Medical Examiner	Sequentially if any, leading cause. Enter Cause (Discontinuity of that initiated rasulting in		{	c	Due to	(or as a consequ	uence of):			3		
Physician/M		21					deriying ceusa gi	ven in Part I.		bacco uae co		o the cause of deat
Completed by			1	Cari	wan	of bre	ast, Hy	ectersion	24a. Was ar perform	n autopsy ned?	24b. Wa	ara autopsy findings allable prior to mpletion of cause death?
	/	e/mores	+ 1	Pace mo	· her,	autic	Storos	(Y	1 ☐ Ye	s 2MNo	10	Yes 2□ No
ation: To Be	examina	2 No of Death ral 5 □ Pa	ŀ	28a. Date		□ ER/Outpatient 28b. Tima of Injury	28c. inju Wo	ner: 4 Nursing H	ome 5 Reside 28d. Describe ho	nce 6 Oth		/)
Certification:	3 ☐ Suid 4 ☐ Hon		uld not be ermined	28e. Place building	of Injury - At ng, atc. (Spec	home, farm, stre	et, factory, office		28f. Location (Str City or Town	eet end Numb , State)	er or Rura	l Route Number,
edicai	29a. Certifia (Check one)	1. 1. Certi only 2 Medi	fying Phys cal Exami	elcian: To the ner: On the ba and mann	isls of examir	nowledga, daath nation and/or Inve	occurred at tha tilestigation, in my c	me, date and place, pinion, death occur	, and due to the ca rred at tha time, da	usa(s) and ma te and place,	nnar as st and due to	ated. the cause(s)
Me		re and take at con	tifier		or stated.		29c. Licens	se number	29	d. Date signe	d (Month, I	Day, Year)
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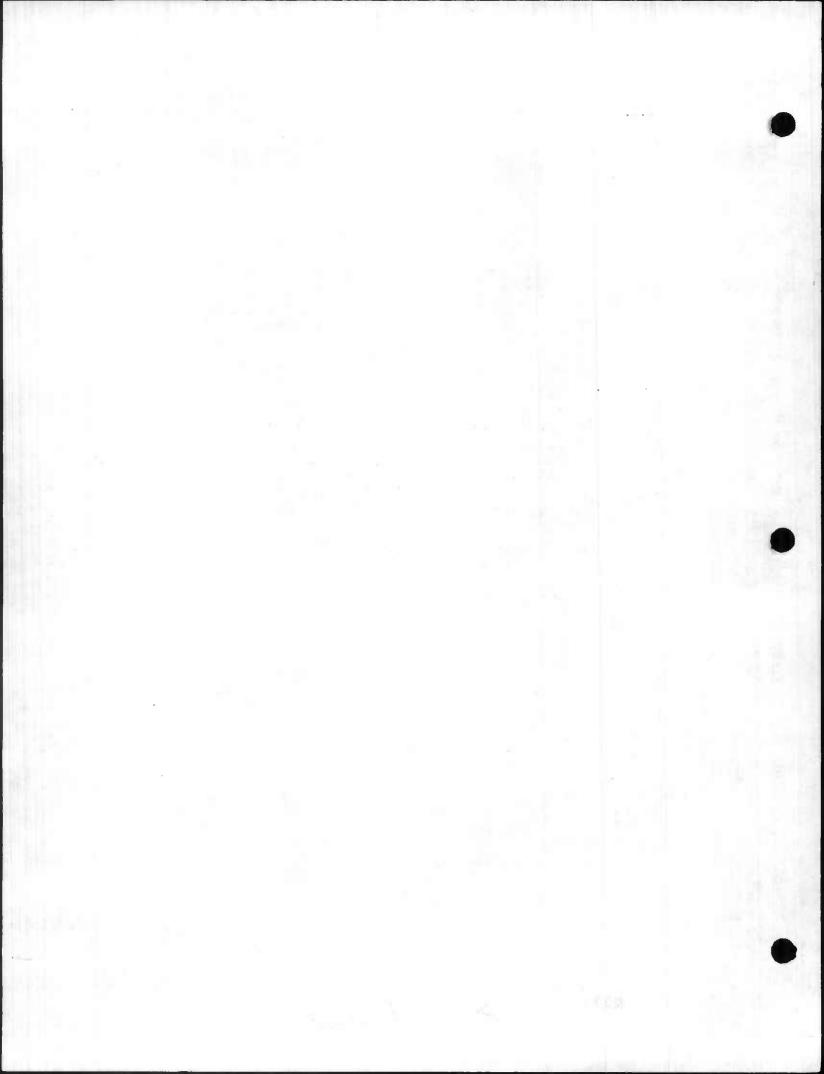


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Elizabeth Catherine Newton March 1, 1999 /Medical 12:30 PM 4a Fscility Nama (If not institution, giva street and number) 4c. County of Death Examiner Salisbury, Salisbury Center: Genesis ElderCare MD Wicomico If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Months Days April 11, 1926 Delaware Director 222-12-4915 Usual Rasidance of Decedant The Maryland 10a Stata 10c. City, Town or Location 10b. County 10d Inside City Limits 1 TYas 2 XNo Director 28a-f Wicomico Sharptown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 P.O. Box 111 21861 Berns 23a USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 72 hours after 1 ☐ Nevar Married 2 Married Baltimore, Maryland 21215-0020 8 1 Yas 2 XNo Specify: à 3 ☐ Widowed 4 ☐ Divorced White "natural". Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 9 Seamstress Garment Factory is marked other 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Pages 1 and 2 should be fill ment of Health and Mental H ant; if them 27 is marked oth lury or other traumatic even Be Clarence L. Collins Lena Steele Collins 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) Edward Collins Newton/Husband P.O. Box 111 Sharptown, MD 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata Dete 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Seaford, Delaware Odd Fellows Cemetery 3-4-99 21. Signatura of Funaral Sarvice Licensee 22. Name and Address of Facility Short Funeral Home, Inc. Part 1. Enter the disease, or complications that caused a principle shock, or heart failure. List only one cause on each line 700 West St. Laurel, DE 19
Do not entar the mode of dying, such as cardiac or respiratory arrest, 19956 Approximete Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final diseasa or condition resulting in deeth) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Due to (or es a consequence of): Box 68760, Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 | Yes 2 2 No 3 | Probably 4 | Unknown Completed by 24b. Were autopsy findings available prior to completion of causa of death? 24a. Wes an autopsy performed? 1 Yas ZONo 1 Yas 2 No certificate Division of Vital 25. Was casa rafarred to medical examinar? or Attending Physician; Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To this 27. Manner of Death 28a. Dete of Injury (Month, Dev Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Invastigation 1 Natural 24 hours after death. 1 Yas 2 No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifiar Medical completely (Check only one) within 2 200 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who complated cause of death (Item 23a) (Type, Print) 1104 Opine\_

DHMH 16 Rev 6/95

State Registrar nus

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Mary Overmeyer March 4, 1999 1:30 PM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Bethesda Montgomery Brighton Gardens If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 6 Sax **Funeral** Months Deys 1 ☐ M 2 🖾 F Yrs 94 Director Aug. 23, 1904 Pennsylvania 205-26-3814 with the Maryland 10c City Town or Location 10a State 10b County 10d Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at 1 Tyes 217 No Directo Maryland Montgomery Bethesda 10e. Street end Number 10f, Zip Code 10g. Citizen of What Country? 5550 Tuckerman Lane #254 20852 Funeral United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mentel Hygiena. Important: if item 27 is marked other than "naturel", or item any injury or other traumatic event, the Medical Examples. Once. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify þ 3 ₩ Widowed 4 Divorced White Completed 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Pasquale Riccio Teresa Ferrucci 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informent's Neme/Reletionship (Type, Print) 8900 Maxwell Drive, Potomac, Maryland Jane Scheetz/Daughter 20854 20b. Plece of Disposition (Name of 20e. Method of Disposition Dete 20c. Location - City or Town, Stete complete, crematory or other place)
t. Peter's Roman Catholic
Church Cemetery March 8, 1999 Columbia, Pennsylvania 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee M00198 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or he at feiture. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel Cerebral Infarct 1 week disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner Dysphagia 1 week requires that the deeth certificate be executed physician end the burial-tran Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Hypotension P.O. Box 68760 3 days Physician/Medical Due to (or es e consequenca of) 88 attending usa ò per Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? detach signed by 1 Yee 20 No 3 Probably 4 Unknown Hypertrophic Cardiomyopathy Division of Vital Records, by 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed peen has page 2 1 Yes 21€ No 1 Tyes 2 No certificata To the Hospital or Attending Physician: within 24 hours after death.

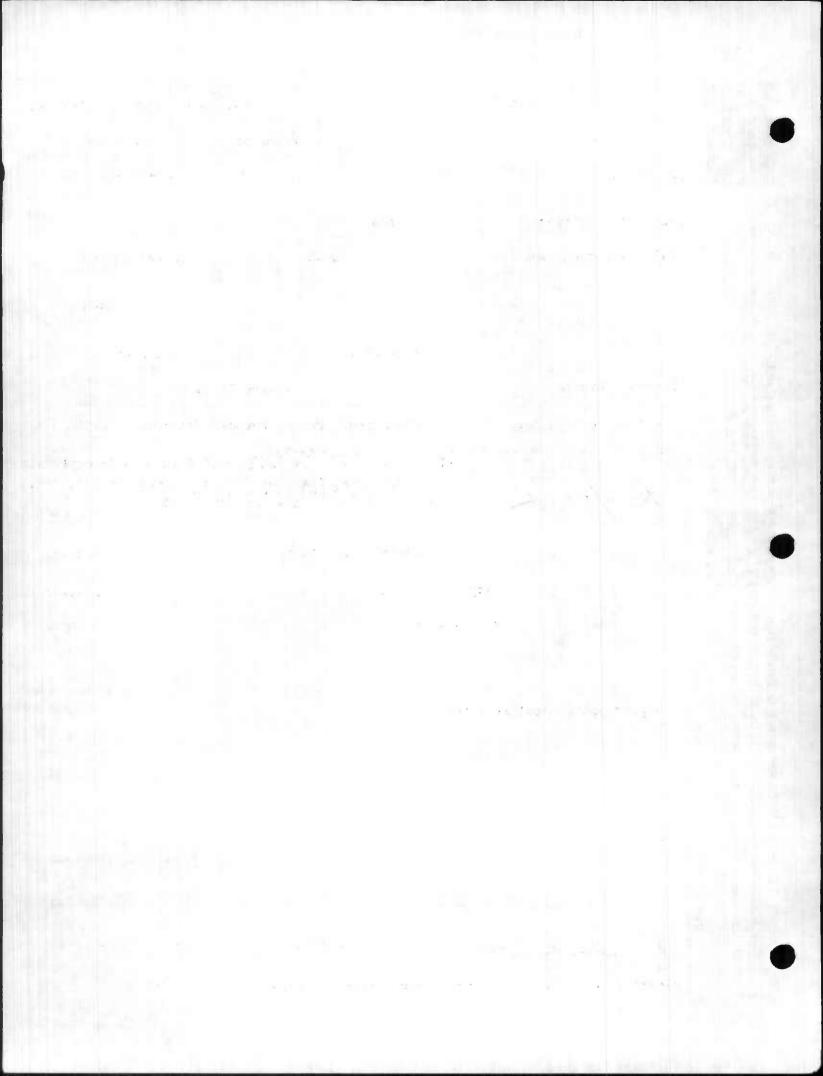
To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4☑ Nursing Home 5☐ Residenca 6☐ Other (Specify) 2 1 Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1XI Certifying Phyetolan: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner es stated.

2 Medicat Examtner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. edicai 29a. Certifier 29b. Signature end title of cartifier 29d. Dete signed (Month, Day, Year) 29c. License number D31282 March 4, 1999 albert Las my 10 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Albert K. Lee, M.D. 8218 Wisconsin Avenue, Bethesda, Maryland

State Registrar 31. Dete filed (Month, Day, Yeer) MAR 0 8

32. Registrer's Signature

20 nec



625 Kent Ave Cumberland,

32 Registrar's Signeture

Maryland

State of the

Registrar

State

Qamar Zaman

31. Date filed WAR 1 1999

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records.

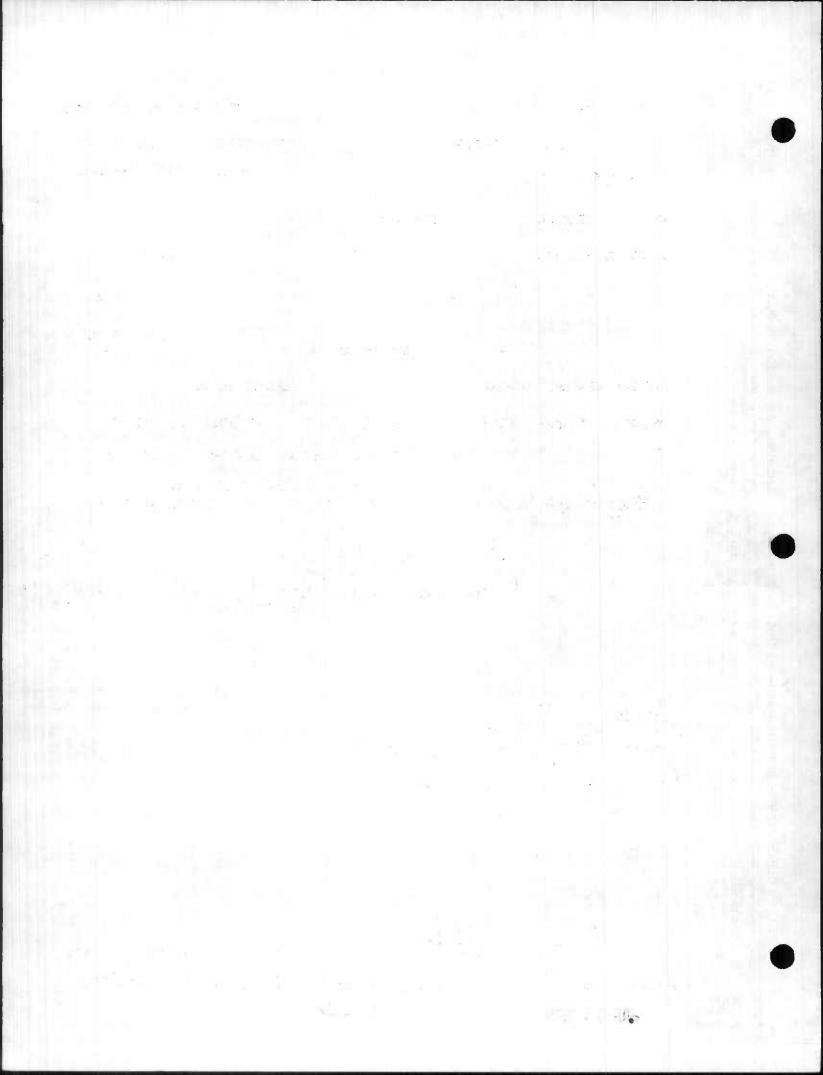
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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Nam	e (First, Middle, Las	st)		001	tificate c		Juli	2. Date of De			3. Time of Death
Physic	_	ALFREI	DAVID	O'BAKE	R					Month FEBRUA	Day	Year 1999	2025
/Medi Exami			If not institution, give					41	b. City, Town, or L	1		nty of Death	2023
		SACREI	) HEART	HOSPI	TAL				CUMBER			LLEGA	NY
Funeral Director		5. Social Security Number  217-30-1823  6. Sex  1 M 2 F  7. Age (In yrs. last birthday)  6. Sex  Months  Days  Hours  Min.							Hours Min.	8. Date of Birt Month, Da AUG . 14	, 1935	9. Births Cour MARY	place (State or Foreign http://
deeth with the Meryland ms 23a or 28a-f show	-	Usual Residence o	10b. County	-	10c. City, To							1	1 ☐ Yes 2√ No
the M	ecto	WV MINERAL RIDGELEY  10e. Street and Number									10g. Citizen o	d What Cour	
with with	Di	10e. Street and Number 10f. Zip Code 2675.								174	U.S.		wyr
P 2 2	by Funeral Director	11. Marital Stetus	led 🎇 Married	12. Was Deceden		13. V		of His Cubar	spanic Origin? (Spanic Origin? (Spanic Origin?) (Spanic Origin)	pecify Yes or No Bloan, etc.)	14. R	eca - Americ lack, White,	etc.
22 hou	pet	(600)	15. Decedent's Ed	ucation		e. Deced	lent's Usual Oc	ccupa	tion	kina	16b. Kind of	Business/In	dustry
ges 1 and 2 should be filed within 72 hours of to Health and Mental Hygiene. If item 27 is marked other than "naturel", or or other treumetic event, the Medical Exam	Completed	Elementery/Seco	ondary (0-12)	College (1-4o		(Give kind of work done during most of workin life. DO NOT use retired)  MAINTENANCE CHIEF					WESTERN MARYLA HOSPITAL		
Hyg office	BeC	17. Father's Neme	(First, Middle, Last)					T	18. Mother's Nan	ne (First, Middle,	Maiden Sum	ame)	
should be nd Mental marked o	ToB	ALFRED CHARLES O'BAKER DOROTT								IY M. DU	NN		
d 2 should be file th end Mental Hy 7 is marked oth traumatic event			ame/Relationship (						nd Number or Ru			vn, State, Zip	Code)
1 end Health em 27			. O'BAKE	R / WIFE			E 3, BC sition (Name of		118 - RI	1		6753	
P S S S S S S S S S S S S S S S S S S S			position Cremation 3  5 Other (Specify		cemet	ery, cren	MEML. G	place	DENS 3	Date 5/4/99	LAVA	LE, M	
Dalim permit. Peg Department Important: I any injury o		Skeric	neral Servica Licen  de diseese, of comput failure. List only	hurch	ed the deeth. Do		202 GRE	HEN	FUNERAL E ST., C	UMBERLA	ND, MD	21502	Approximete Interval Between
Physician /Medical Examiner	er	Immediate Cause disease or condition resulting in death)	(Final	a. Pos	PIOAT Due to (or ass	s coused	unto on:	5/1	sne 2				Onset end Deeth  48 House
BOX 06/00, sath certificate be executed ettending physician and for use as the buriel-transit	n/Medical Examiner	Sequentially list on if any, leading to incause. Enter Unde Cause (Disease or that Initiated event resulting in death)	5	b. CAN c	Due to (or as a				ALON	estres.	.147		r419, 1776
death cert e ettending ed for use	lclan/M	Part II. Other signif	licant conditions of	ontributing to death	but not resulting	in the ur	ndertving cause	nive	on In Part 1	23b. Did	tobacco use	contribute t	o the cause of death?
D. Det the detached	y Phyta	DASCI	85 Nel	live	out not resulting	iii die di	idonying outdoo	give	ar ny r care i,	10			
v requir	Completed by Phys	GNO	APR	ER	20L	2	SENTE				an autopsy	81	fere autopsy findings vallable prior to ompletion of cause death?
VICAL DE lavidician: The lavidicate hes	omo	(draw	PRY A	72001	WSE.	THE	)			10	Yes 250 No	1	□Yes 2□No
ysician: The i	Bec	25. Was case referexaminer?	red to medical	4000		1 2			26. Placa of Dea	ith (Check only o	ne)		
Physician: this certific ral director,	To	1 ☐ Yes 2 Þ	No	Hospital: Sanpa		Dutpatien		Othe	4 LI Nursing H	ome 5 Resi			fy)
Ing P	lon:	27. Manner of Deat 1 Matural	5 Pending	28e. Date of fn (Month, D	lay Year) 28b	. Time of fnjury	28c. 1			28d. Describe	how Injury oc	curred	
Corving of the fune of the fun	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigation 6 Could not be determined	28e. Placa of f	njury - At home, etc. (Specify)	farm, str			/es 2□No	28f. Location ( City or To	Street and Nu vn, State)	m <i>ber</i> or Rur	al Route Number,
To the Hospital or Attending Phywithin 24 hours effer death. To the Funeral Director: Affer thi completely filled in by the funeral	edical Ce	29a. Certifier (Check only	1 Certifying Phy	ysician: To the bes	t of my knowledg	ge, death	occurred at the	e tim	e, dete and pleca	, and due to the	cause(s) end	menner as s	stated.
To the Hospital within 24 hours To the Funeral completely filled	Medi	one) 29b. Signeture and		and manner					number	To at the time,	29d. Dete sig		
6		•	1 /5	SOUTK	04	_	D	)3	31875		MARCH	1.	1999
Ju	8	Kobert	welk.	4.D.90	a Set	(Type,	Drive	(	umber	land M	10 3	1150	2
Sta Regist		31. Date filed (Mon	th, Day, Year)	32. Regis	trar's Signature	g. ,	fered	4					

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** GRITCHALD THOMAS 2200 EDWARD MARCH 03 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth **Examiner** MONGOMERY HOLY CLOSS Shuba South HOSPITA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthpiace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F Yrs Director 213-58-9399 46 March 26,1952 Washington, D.C. Usual Residence of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow 1 ☐ Yes 2 ☐ No Directo Maryland | Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiena.
Important: If item 27 is marked other than.
Important: If item 27 is marked other than.
Interpret marked other than a natural, or items 23s or 3 and hyllury or other traumatic event, the Medical Evantiver must be in once. Funeral 2677 Cory Terrace 2090.2

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA 14. Raca - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Bieck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Washington Post 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be 2 Charles Raymond Pritchard Margaret S. Parris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret P. Pritchard (Mother) r) 2677 Cory Terrace Wheaton, Maryland 20902

20b. Place of Disposition (Neme of cemetery, cremetory or other plece)

Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 03/8/99 Silver Spring, Maryland Gate of Heaven Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 23a Party Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate

Approximate Approximete Intervai Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) EMUROST Examiner Due to (or as a consequenca of): Examiner physician and the bunal-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequenca of): Box 68760. Physician/Medical Due to (or as a consequenca of): 98 esn ed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. signed by I 4 Winknown 1 Yas 2 No 3 Probably P 24b. Were eutopsy findings available prior to Completed 24a. Was an autopsy completion of cause page 2 20 No certificata Physician: 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 1 Dyspatient To 2 ER/Outpatient 3 DOA After this 28a. Dale of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours efter death. 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and menner stated. Medical completaly within 2 To the 29b. Signi nd title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) OME. 15236 MARCH 05, 1999 2

State Registrar 31. Dete filed (Month, Day, Year)

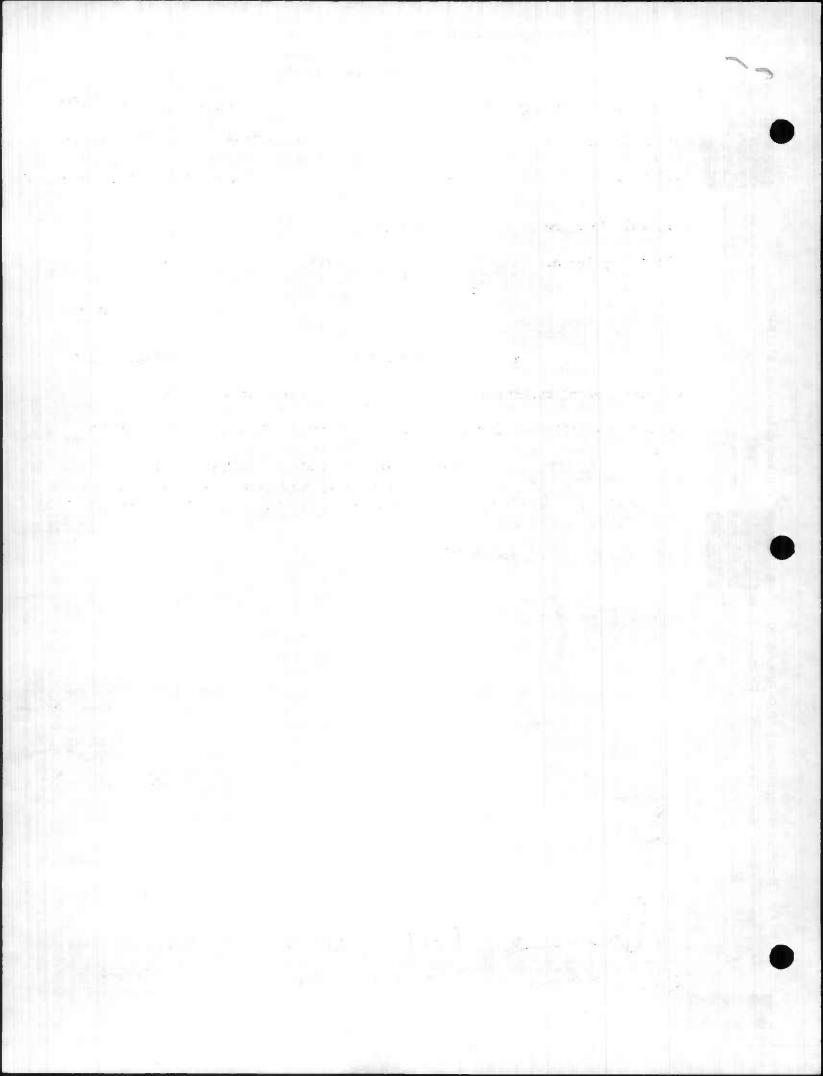
32. Registrar's Signature MAR 1 0 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAU I. MAGOUS, M.O. IIVS DOCKULUR AKE

Bocking, mo 20852

**DHMH 16 Rav 6/95** 



99-1184-005

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

DAVID

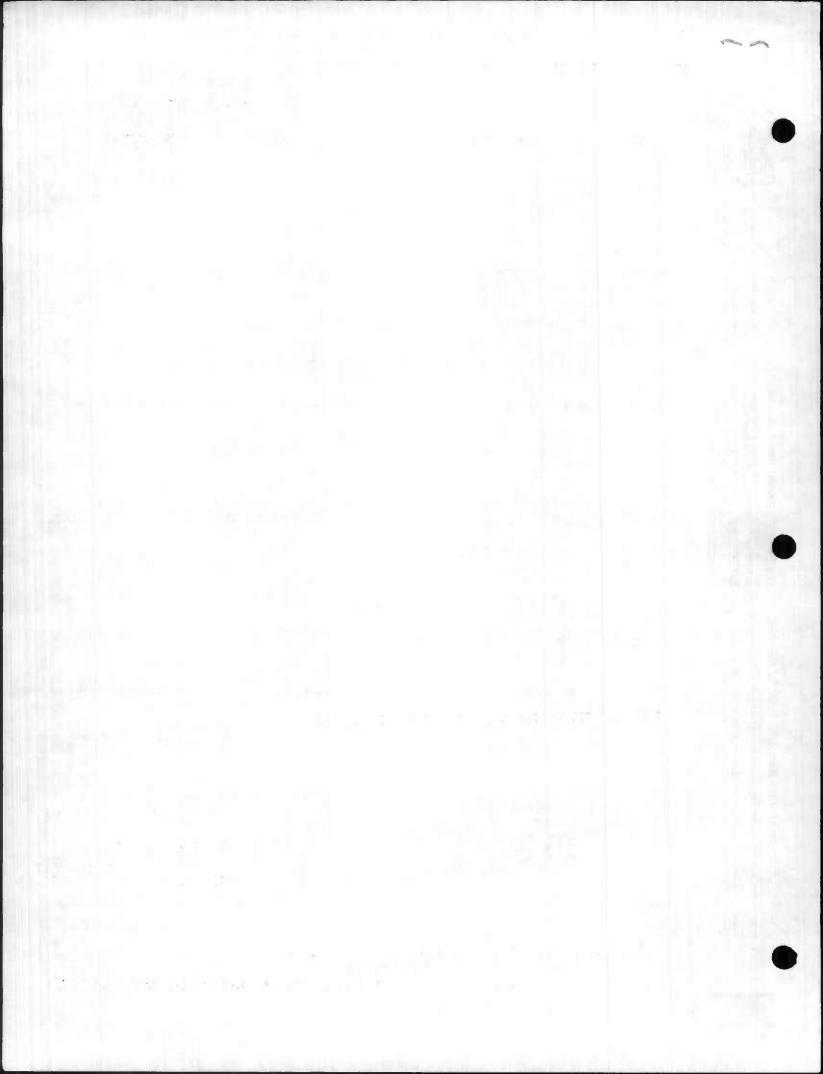
Box 68760 certificate be PO hes certificate Division of Vital this After or Attendin efter death. Director: Aft Hospital 24 hours 8 24 hours

State of Maryland (Department of Health and Mental Hygiene ITEMS: #23 PART I, II, 27, 28A-F PER MEO Certificate of Death **PEDERSON** 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** David Erling Pedersen MARCH 1999 2:16P.M. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PULASKI HWY & MARTIN BLVD. **ESSEX** BALTIMORE If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Oct. 31, 1 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Min **X**M 2□ F Months Days Hours 43 Yrs. 230-88-4579 Maine Director Usual Residence of Decedent the Merylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or ferms 23s or 28s-f show traumstic event, the Modical Express, must be notified at 1 Yes 2 No MD Baltimore Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2000 Barry Road 21222 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. 11. Maritel Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygione. Important: if Itam 27 is marked other than "natural", or ital any injury or other traumatic event, tre Modical Exam 1 Never Married 2 Married 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Electronics Elementery/Secondary (0-12) College (1-4or 5+) Manufacturing Electronics Technician 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) Be Arnold Kenneth Pedersen Frances Eleanor 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arnold Pedersen Powhatan, VA 23139 1454 Country Forest Lane 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Powhatan Community Cem. 3/8/99 4 ☐ Donetion 5 ☐ Other (Specify) Powhatan, VA 22. Name and Address of Fecility
Bennett-Baden Funeral Home 21. Signature of Funeral Service Licensee 3215 Anderson Hwy. Powhatan, VA Part In r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, and earl failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final HYPERTHEMIA disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner ician end buriel-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): physician s the buriel Physician/Medical Due to (or es a consequence of): 980 23b. Did tobacco use contribute to the cause of death? ed by the deteched Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown ATHEROSCLEROTIC CARDIOVASCULAR DISEASE CHRONIC ALCOHOLISM à 24b. Were autopsy findings svailable prior to Completed 24a. Was an autopsy performed? completion of cause of deeth? 1XYes 2 No 1 Yes 2 No 25. Wes case referred to medicat Be 26. Piece of Deeth (Check only one) Other:  ${}_{4}\square$  Nursing Home  ${}_{5}\square$  Residence  ${}_{6}$  XOther (Specify) WOODS 1 XYes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Ound: 3-1-99 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Certification: 1 Natural 5 Pending UNKNOWN 1 Yes 2 No investigation PROLONGED EXPOSURE TO COLD 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) PULASKI HIGHWAY AT 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide WOODS MARTIN, BLVD., BALTIMORE COUNTY, MD. 1 Certifying Physicisn: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) and manner stated. 29a. Certifier edicai (Check only one) To the To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. MARCH 2, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Radentz 5 Stephen 111 Penn Street, Baltimore, Maryland 21201 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State MAR 0 9 1999

Registrar

**DHMH 16 Rev 6/95** 



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Papanicolas Aphrodite 1999 March 6, 8:10 p.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 3505 Preston Court | Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 23, 1 Chevy Chase Montgomery 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛣 F Yrs. 1916 242-05-8986 83 Director Usual Residence of Decedent with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD Montgomery Chevy Chase 1 ☐ Yes 2 No Director 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 5 items 23a 3505 Preston Court 20815 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours efter d Department of Heelih end Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or Item any Injury or other traumatic event, the Medical Exempted. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White by 3 NWidowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) George Chrysson Mary Chrystal 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Alexander Papanicolas/Son 1 Earth Star Place, Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) 3/10/99 Rockville, Maryland Parklawn Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue N.W., Washington, D.C. 20016 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. Untroniy one ceuse on each line. Approximate Intervai Between Onset end Death **Physiclan** Immediate Cause (Fine) disease or condition resulting in death) /Medical Examiner physician and s the burial-trensit thet the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medicai attending p Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? á NZ Yes 2 No 3 Probably 4 Unknown signed t Records, à 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed peeu page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificate Division of Vital To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Was cese referred to medical 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier March 8, 1999 30. Name and address of person who completed ceuse of death (item 23a) (Type, Print) Gita C. Bakshi M.D., 9406 Old Georgetown Road, Bethesda, MD 20814-1722 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State MAR 10 Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Yeer **Physician** MARIA K. PENKO 1999 March 6, 1:50am /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death **Examiner** Shady Grove Adventist Nursing Center Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 6. Sex **Funeral** Months Deys Hours 1□ M 25 F 79 Director July 22, 1919 169-14-5314 Iceland Usuei Residence of Decedent with the Meryland 10e. State 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be nothed at 1 ♥ Yes 2 No Montgomery Gaithersburg 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ă 401 West Diamond Ave permit. Peges 1 and 2 should be filed within 72 hours efter deeth v Department of Haaith end Mental Hygiene. Important: if item 27 is marked other than "natural, or items 23s any injury or other traumatic event, the Medical Examiner must obtice. 20877 United States Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 14. Rece - American Indian, Black, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Karl Nielsen Kristin Gudsdottier 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Karl M. Penko (Son) 23 Spinning Wheel Ct. Germantown, Md. 20874 20b. Pleca of Disposition (Name of cemetery, cremetery or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Steta Mar. 8, 1 ☐ Buriel 2 ☒ Cremetion 3 ☐ Removel from State Alexandria, Va. 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 1999 22. Name end Address of Fecility DeVol Funeral Home 21. Signeture of Funerel Service Licen; Curtes 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Pert1. Enter the disease, or complications wat caused the deeth. Do not enter the mode of dylng, such as cerdiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting In deeth) /Medical Colon Cancer Metastatic 2weeks Examiner Due to (or as e consequence of): Examiner physician and the bunal-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of) Physician/Medical thel initieted events resulting in death) Last Due to (or es a consequence of) 88 attending p signed by the a d be datached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cardiac Arrythmia à 24b. Were autopsy findings avellable prior to completion of ceuse of deeth? been si 24e. Wes en eutopsy performed? Completed pege 2 has 1 ☐ Yes 2 No certificate after death.

Director: After this certifications director, Be 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) To Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 ☒ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending Investigation 1 Naturel 1 Yes 2 No 2 Accident the Funeral Director filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifie 🗓 Committing Physician: To the best of my knowledge, death occurred at the time, date end pleca, end due to the cause(s) and manner es stated. Medicai To the Hosp within 24 ho To the Fune completely f (Check only one) Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. 29b. Signeture and title 29c. License number 29d. Dete signed (Month, Dey, Year) D28656 March 8, 1999 30. Neme end eddress of person. he completed cause of deeth (Item 23e) (Type, Print) Dr. Ravi Passi M.D. 8609 Second Ave. #404B Silver Spring, Md. 20910 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

Registrar

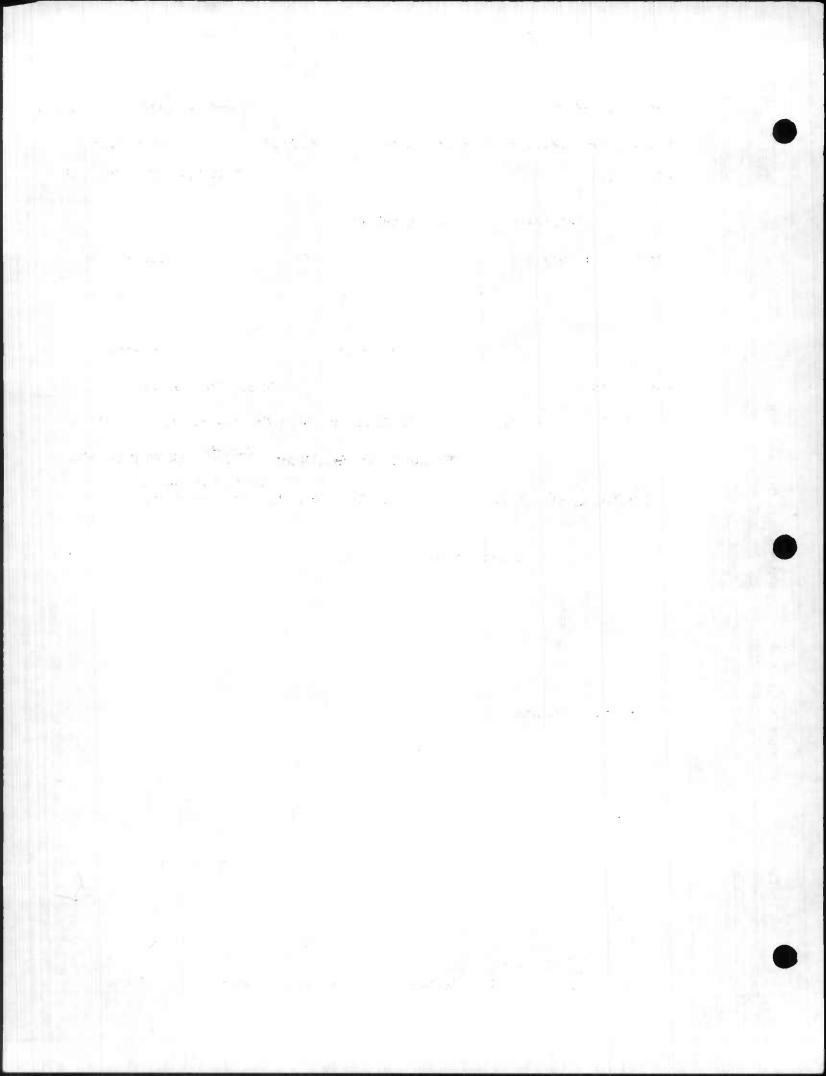
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**DHMH 16 Rev 6/95** 

 $\omega$ Baltimore, Maryland 21215-0020

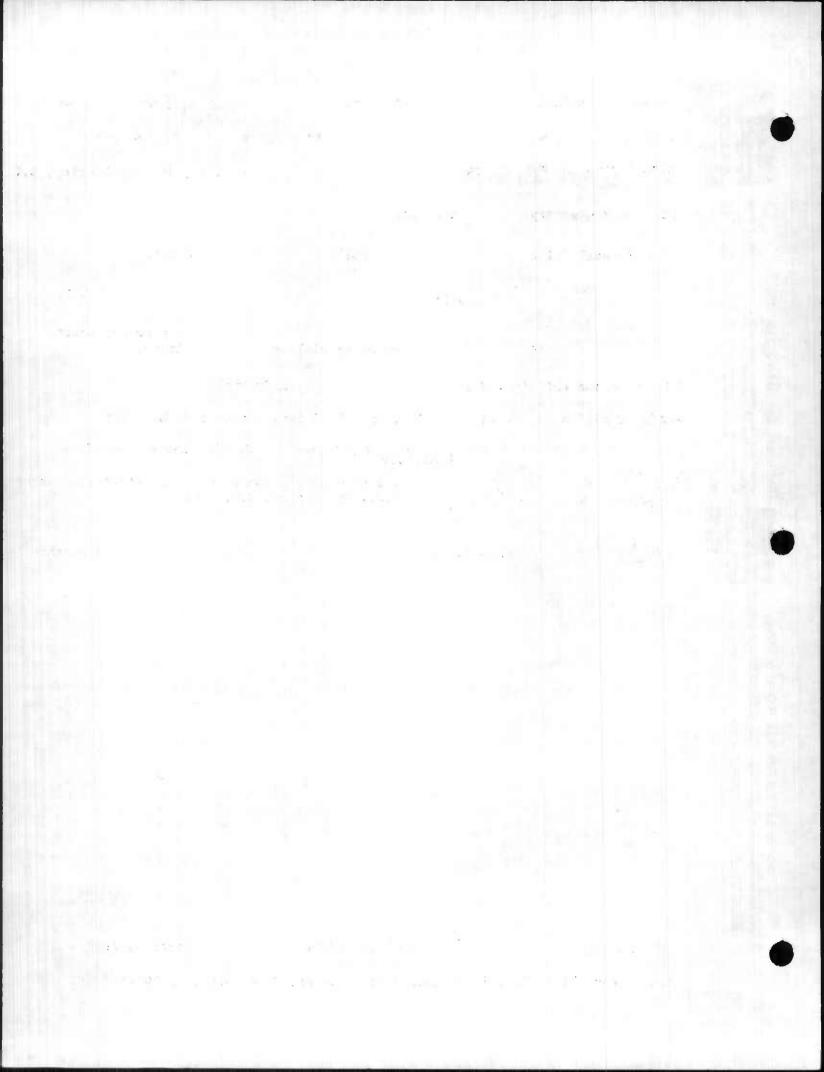
P.O. Box 68760.

Division of Vital Records,



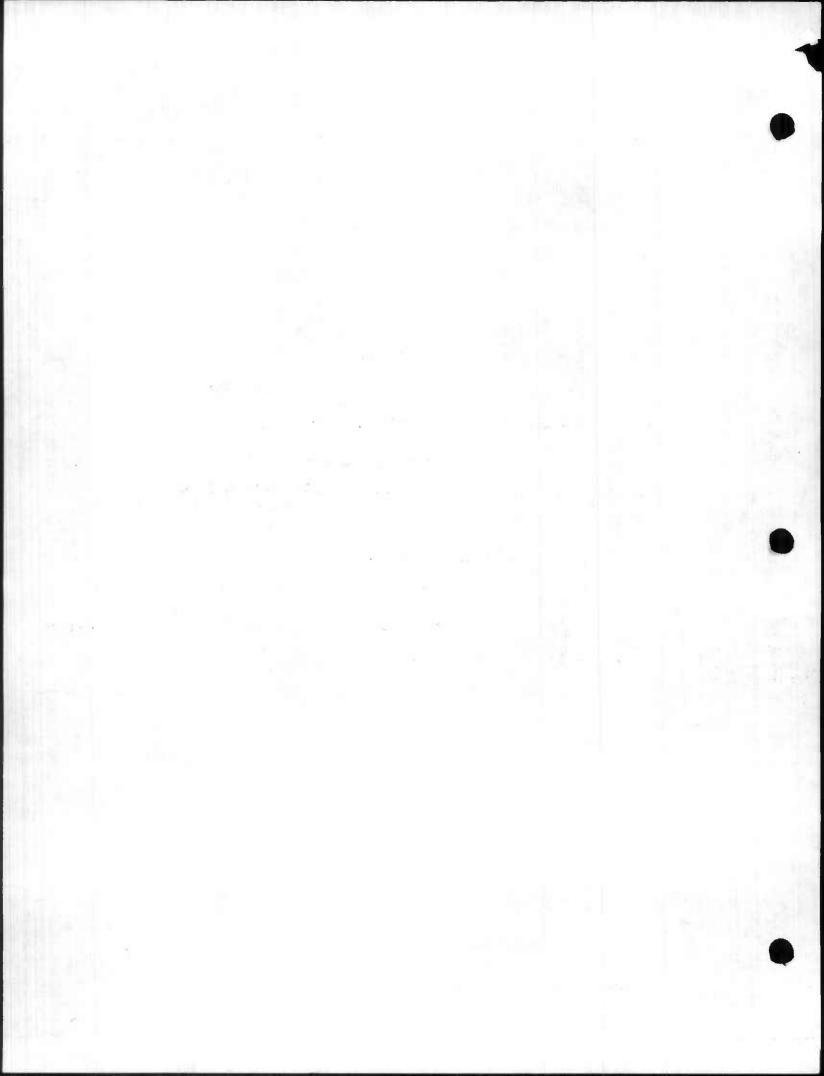
# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q

	1. Decedent's Nama (First, Middla, La	st)	00111	ficate of	- outi	2. Data of De	Reg. No.	3. Tima of Death			
Physician	Edward Rolan		hillips,	Jr.		Month March	4, 1999	6:30 p.m			
/Medical Examiner	4a Facility Nama (If not institution, giv	a street and number)			4b. City, Town, or						
	4110 Spruell Dri				Kensingt		Montgo	,			
Funeral Director	3/9-24-//00	7. Aga (In yr. 75)		If Under 1 Year Months Days	Hours Min.	(Month, De	th ly, Yaar) 0, 1923	9. Birthplace (Steta or Foreig Country) Washington, D.	n C		
Maryland f show	Usual Rasidance of Decedant  10a. Stata 10b. County  MD Montgome		Dity, Town or Local	tion				10d. Inside City Limits			
rect	10e. Street and Number			10f. Zip Coda			10g. Citizan of V	Vhat Country?	-		
h with	4110 Spruell Dri	ve		20895			U.S.A.				
To Be Completed by Function 12 hours after death with the Maryland of Health and Mental Hygiene.  To Be Completed by Function 12 hours of the	11. Marital Status  1 □ Navar Marriad 2 ☑ Married  3 □ Widowed 4 □ Divorcad	12. Was Decedent Evar in Armed Forces? 1 ∰Yas 2 ☐ No If Yas, Giva Yaar or Datas: WWI	40	s Decedant of I as, specify Cub Yes 2 No	Hispanic Origin? (S lan, Maxican, Puan Specify:	pecify Yas or No o Rican, atc.)	14. Raci Blac Specify	a - Amarican Indian, ck, Whita, etc. White			
ded within 72 hours aff lygiene. "nature!", or ner than "nature!", or nt, tre Mexical Exam Completed by F	15. Decedant's Ec (Specify only highast gra	da completed)  Collega (1-4or 5+)			pation during most of wo	rking	Montgo	mery County			
Hiled with Hygiene. ther ther and, its a	17. Fathar's Nama (First, Middla, Last)	4+	Comput	er Spec		ma (First Middle	Library st, Middla, Meldan Sumama)				
Mental H Mental H Mental H Mrked oth Mrked oth To Be	Edward Roland Phi					s Nama (First, Middla, Meldan Sumama) Criswell					
d 2 should be file th and Mental Hy 77 is marked othe traumatic event	19a. Informant's Name/Ralationship (		19b. Mailing	Addrass (Straa		TSWELL  fural Routa Number, City or Town, Stata, Zip Coda)					
and 2:	Eunice Phillips	Wife	Drive, K	ensingto	on, MD 20	0895					
2 4 4 5	20a. Mathod of Disposition 1 □ Burial 2 ☑ Cramation 3 □ 4 □ Donation 5 □ Øthan (Spacify	IRamoval from Stata	gton	3/8/99		City or Town, Stata Maryland					
permit. Departm Importa any Inju	St. Signature of Funeral Egylice Licer	isconsin Avenu	e								
Physician /Medical Examiner	23e Pant. Enter the disease, or com- shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	. Lung Canc			ng, such as cardia	o i laspilatory e	inast,	Approximata interval Between Onsat and Death  3 months			
rificate be axecuted in physician and as the burial-transit	Sequentially list conditions, if any, laading to immadiate cause. Entar Undarlying Ceusa (Diseese or Injury that initiated avants rasulting in death) Last	cDua to	(or as a consaqua								
eath certifica ettending ph for use as t		d									
nat the death cert d by the ettendin stetached for use	Part II. Other significant conditions of	ontributing to death but not re	asulting in the unde	adying causa gi	ven in Part I.		ntribute to the cause of death				
Iden: The lew requires that the death cent centificate has been signed by the ettendin rector, page 2 should be detached for use.						24a. Was	an autopsy ormed?	24b. Were autopsy findings available prior to completion of causa of deeth?			
ysician: The k sis certificate he director, paga						10	Yes 2 ☑ No	1 ☐ Yas 2 ☐ No			
certificate rector, pag	25. Was casa rafarrad to medical axaminar?	Hospital:		0.		ath (Check only	one)				
2 0 D	1 Yas 2 2 No	1 ☐ Inpatiant 2	☐ ER/Outpatient 28b. Tima of	3LI DOA		_	danca 8 Oth				
tal or Attanding Physical Collector: After this is Director: After this led in by the funeral of Certification: To	1 XNatural 5 Panding 2 Accidant invastigation 3 Suicida 6 Could not b.	(Month, Dey Year)	Injury		rk? Yas 2 No			per or Rural Routa Number,			
To the Hospital or Attanding Physicial Complete or Attanding Physicial A hours stated death. Or the Funeral Director: After the completely filled in by the funeral Medical Certification: 7	4 Homicida datarminad										
To the Hospital within 24 hours a To the Funeral I completaly filled Medical Ce			annar as stated. and dua to tha cause(s)								
Within To the comple	29b. Signature and title of certifiar 29c. Licansa number 29d. Data signed (Month, Da							d (Month, Day, Year)			
(0)	Donal Crall D04766 March 5, 1999  30. Nama and addrass of person who completed cause of deeth (Item 23e) (Type, Print)										
	Daniel Rosenblum				nue. Kens	sington.	MD 2089	95			
State Registrar	31. Data filed (Month, Day, Year)	32. Registrar's Sign		hoory							



State of Maryland / Department of Health and Mental Hygiene

			(	Certificate of	Death		Reg. No. 99	09272			
Physician	1. Decedant's Nama (First, Middla,	Last)				2. Date of Dea		3. Time of Deal			
/Medical		Lucy Julia	Powe	11		March	7, 1999	12:05 P			
Examiner	4a Facility Nama (If not institution,	giva street and number)			4b. City, Town, or I		4c. County o	f Death			
	13205 Locksley				Silver Sp		Montgo				
Funeral Director	156-20-9052	1 M 2 XE	yrs. last birtho	Months Devs		8. Data of Birt (Month, De April 15		9. Birthplace (State or For Country) New Jersey			
1.	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town o	or Location				10d. Inside City Lin			
or after								1 ☐ Yes 2 🔯			
be notified	Maryland Monte	comery	Silver	Spring 101. Zip Code			10g. Citizen of Wh	nat Country?			
D P C	13205 Locksley	Lano		20904			United				
r herre 23, siner must Furneral	11. Marilal Status	12. Was Decedant Ever	r in U.S.		Hispanic Origin? (S	pecify Yes or No		- American Indian,			
at, or harm 23a or 28a-f shore Examiner must be notified at by Furneral Director	1 Never Married 2 Marrie	Armed Forces?		<ol> <li>Was Decedent of I If Yes, specify Cub</li> <li>Yes 2Ñ No</li> </ol>		o Rican, etc.)	Specify:	, Whita, atc. White			
sales a be	15. Decedant's	Education	16a. D	ecedent's Usual Occup	pation		16b. Kind of Bus				
Media	(Specify only highast		(6)	Give kind of work dona fe. DO NOT use retire	during most of world)	rking	ng Too. Kind of Business modelity				
ygiene. wr than "naturi r, the Medical.] Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	T	eacher			Pre-school				
d other event, Be C	17. Father's Name (First, Middle, La	est)			18. Mother's Nan	me (First, Middle,	Maiden Sumeme				
Menta infraed iffic en	Rosario Collo	va			Rosin	a Porta	ale				
and h	19a, Informant's Name/Relationshi	p (Type, Print)	19b. N	Mailing Address (Street	t end Number or Ru	ıral Route Numbe	er, City or Town, S	itate, Zip Code)			
27 ls	Roseanne P. Lin	dsay (daught	er) 10	470 Rock C	reek Driv	e, Sano	d Diego.	CA 92131			
oth oth	20a. Method of Disposition	2	Ob. Place of D	isposition (Neme of cremetory or other ple		Date		city or Town, State			
nt: If	1 Burial 2 Caramation 3 4 Donation 5 Other (Spe			eake Cremat	1	3-8-99	Reltevil	le, Marylan			
ortant: ortant: injury	21. Signature of Funaral Service Li		onesape	22. Name and Addre	-01		DETCSVII	ie, narytan			
De la grande	De Ens. C	11 Kino		Rapp Fune:	ral Servi	ces, P.	Α.				
	23a Part 1 Foter the disease or o	omplications that caused the	death Do not	933 Gist	Avenue, S	silver Sp	oring, MI	20910 Approximate			
	23a. Part1. Enter the diseasa, or c shock, or heart failure. List or	nly one cause on each line.	GOAIN. DO NO	ontar the mode of dy	ing, such as outlined	or respiratory at	rast,	Interval Between			
ysician Medical	Immediate Cause (Final										
aminer	disease or condition resulting in death)	a		rcinomatos	is			3 months			
9				nsequence of):							
ansit		D		lungs) En	dometrial	Cancer		l year			
ial-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		to (or es a cor								
g physicien and as the burial-transit	that initiated events	c. Endometi	to (or as a cor					3 years			
	resulting in deeth) Last	000	to (or as a cor	isequence or).							
		d									
d for	Part II. Other significant condition	e contributing to death but as	at reculting in th	no undorbing course di	ven in Part I	23h Did i	oheaca use cont	ribute to the cause of de			
igned by the attendir be detached for use by Physician/N	Tarti. Other alginicant condition	contributing to death but no	or resulting til ti	te underlying cause gr	Ventin Franti.			3 ☐ Probably 4 🖔 Unit			
be det							2010	on receiving			
old blu							an autopsy	24b. Were autopsy finding			
ertificate hes been si octor, page 2 should i Be Completed						perlo	rmed?	available prior to completion of caus of death?			
ge 2							. 677				
ficate or, pa	OS Was once referred to medical					101		1 ☐ Yas 2 ☑ No			
certi	25. Was case referred to medical axaminer?	Hospital:	.57.50	Ott		ath (Check only o					
ral dire	27. Manner of Death	1 Inpatient	2 ER/Outpo	atient 3L DOA	4 LI Nursing H		lence 6 Other				
After fund	1 ⊠Netural 5 □ Pending	(Month, Dey Ye		iry Wo	rk? Yes 2 □ No						
and Director: After the in by the funeral Certification:	3 ☐ Suicide 6 ☐ Could no	t be 28e. Placa of Injury -	At home, farm	, street, factory, office		28f. Location /5	Street and Number	r or Rurel Route Number,			
din t	4 Homicide	building, etc. (S	pecify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tox	m, State)				
within 24 hours after death.  To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 shown that the completely filled in by the funeral director, page 2 shown begins a filled in both the following the filled in th	29a. Certifier 1 Certifying	Physician: To the best of my	y knowledge, d	eath occurred at the ti	me, date and place	, and due to the	ceuse(s) and man	ner as steted.			
n 24 hou he Funer pletely fill edical	(Check only 2 Medical Ex	aminer: On the basis of exa and manner stated.	mination and/o	or investigetion, in my	opinion, death occu	rred at the time,	date and place, ar	nd due to the cause(s)			
Me We	29b. Signature and title of certifiar			29c. Licens	se number		29d. Date signed	(Month, Dey, Year)			
/		Muon	y	7/5	07/		36	1000			
5	20 Name and address of account	700	//tom 22 \ \	D45	2/4		March 8	3, 1999			
	30. Name and address of person with				V	100	20005				
	Cho Maung, M. D	32. Registrar's S		ut Avenue,	Kensingt	on, MD	20895				
State Registrar			w /	Ana v	11						
State Registrar	MAR 0 9 19		w B	. Spark	2						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month 8:00 PM Charlotte P. Pusey March 8, 1999 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth Montgomery
ar If Under 24 Hrs.
s Hours Min. Montgomery Village Care and Rehabilitation Center Village Montgomery Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6. Sex Months 1□ M 2X F Deys 77 577-20-6384 October 14, 1921 Washington, DC Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Potomac 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12405 Over Ridge Road 20854 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 14. Race - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Merried 25 Merried 1 Yes 2 No Specify: Specify. 3 Widowed 4 Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Name (First, Middle, Last) Robert N. Patterson Clay Deal 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Lewis B. Pusey, Jr./ Husband 12405 Over Ridge Road, Potomac, MD 20854 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) March 11, 1999 20c. Location - City or Town, State 20e. Method of Disposition 1 Burlel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Funerel Service Livensee Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 apt enter the mode of dying, such as cardiac or respiratory errest, M00688 se, or complications that caused the death.

List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Cause (Final diseese or condition resulting in death) Emphysema Years Due to (or es e consequence of) Due to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the causa of death? 1⊠ Yas 2□ No 3□ Probably 4□ Unknown Dementia 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Piece of Death (Check only one)

**Physician** /Medical Examiner

be axecuted

Accords, P.O. Box 68760

Division of Vital

**Physician** 

/Medical

Examiner

10a State

**Funeral** 

Director

a notified at

8

Name 23s

be filed within 72 hours after al Hygiene. Cother than "natural", or its

should be fi and Mental H

h and Mental

permit. Pages 1 and 2 at Department of Health and Important: If Item 27 is n any injury or other traum once.

Baltimore, Maryland

the Medical Examiner must be

traumatic event.

Directo

Funeral

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Completed

Be

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Examiner physician and the burial-transit Physician/Medical 88 USB A 0 datached signed l by Completed paga 2 director Be 10 funeral Certification:

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After

or Attending after death. Director: Aft

24 hours

To the Hosp within 24 hor To the Fune complataly fi

10

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case referred to medical 1 Yes 2K No

27. Menner of Deeth 1 XNaturel 5 Pending investigation 2 Accident

6 Could not be determined 3 Sulcide 4 Homicide

28e. Dete of Injury (Month, Dey Yeer) 28b. Time of

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 Tyes 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier

29a. Certifier

(Check only one)

29c. License number 044157 29d. Dete signed (Month, Dey, Year)

March 9, 1999

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

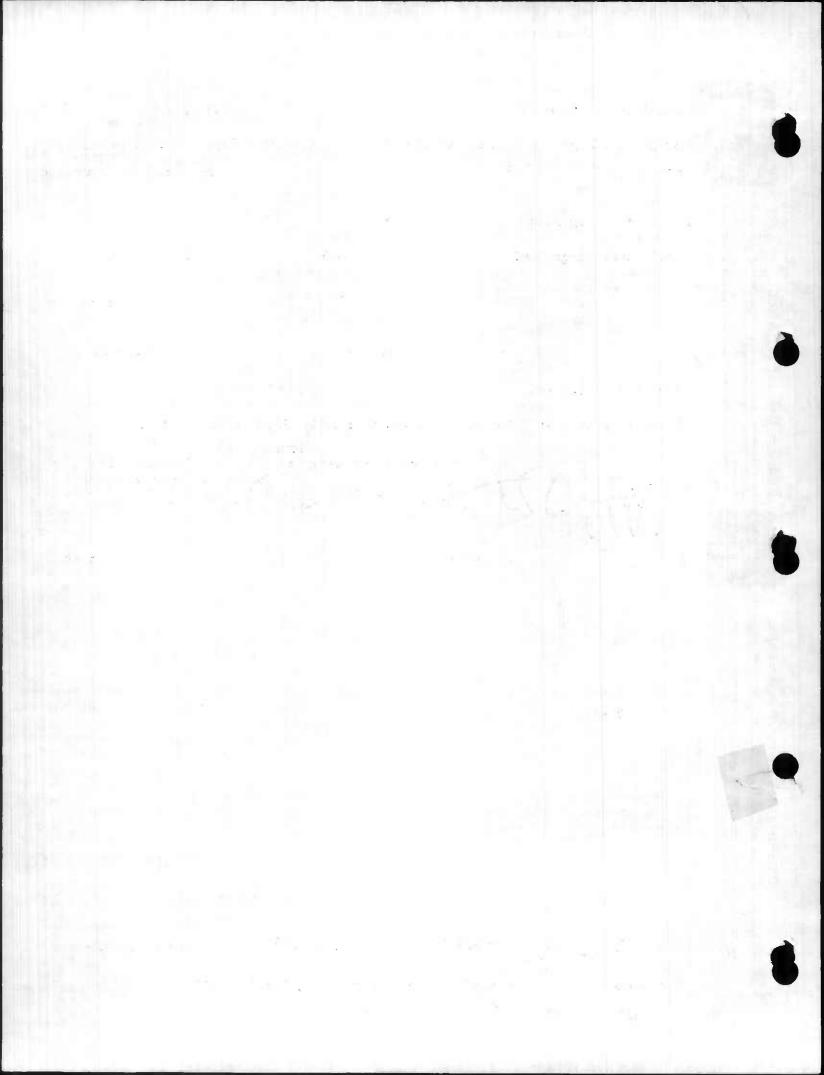
Ira Berger, M.D. 809 Veirs Mill Road, Rockville, Maryland 20851

State Registrar

Medical

31. Dete filed (Month, Dey, Year) MAR 1 1 1999





Box 68760,

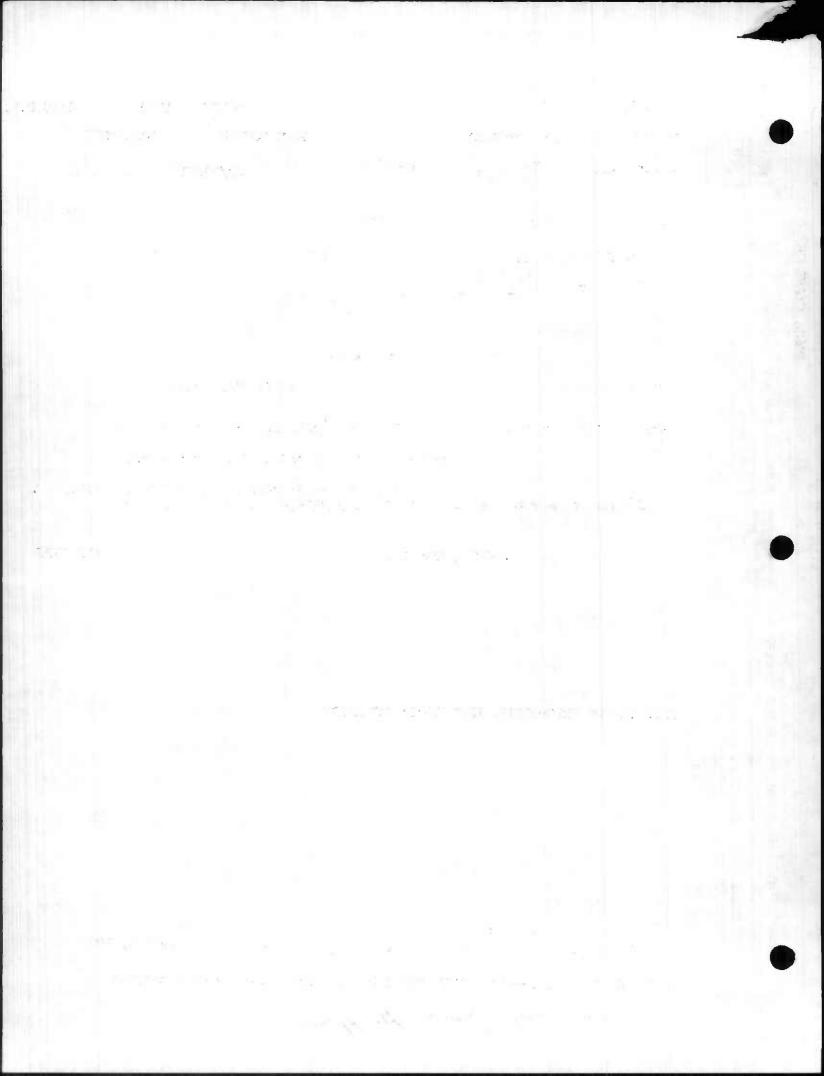
Division of Vital Records,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9

Amended #18, 3/11/99, BA, Taibot Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** CLARENCE PAUL MARCH 5, 1999 4:10 P.M. /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not Institution, give street and number) 4c. County of Deeth Examiner FORT HOWARD BALTIMORE VAMHCS FORT HOWARD DIVISION 6. Sex 1 ☑ M 2 ☐ F If Under 1 Yeer | If Under 24 Hrs. 8. Dele of Birth (Month, Day, Year) 02/20/51 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Deys Hours 411-88-4460 Yrs. 48 MARYLAND **Director** Usuel Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ehow 1XYes 2 □ No Director MD EASTON TALBOT 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code with "natural", or items 23s or 517 GOLDSBOROUGH ST. 21601 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Merilei Status Bleck, White, etc. filed within 72 hours efter 1 XYes 2 No If Yes, Give 1972-1978 Year or Dales: 1 Never Married 2 X Married 1 ☐ Yes 2 ◯XNo Specify: WHITE p 3 Widowed 4 Divorced Completed The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nant of Health end Mental Hygiena.
Int: If Item 27 le marked other than Iry or other traumatic event, The M 12 -0-DISABLED 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BETTY JANE CHEEK SILAS PAUL CHUK 19a. informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 517 GOLDSBOROUGH ST., EASTON, MD 21601 BETTY J. PAUL/ MOTHER Baltimore, 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete permit. Pages Department of Important: If It any injury or o 1 X Buriel 2 Cremetion 3 Removal from State MARYLAND VETERAN CEMETERY 3-12-99 HURLOCK, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Servica Licenses 22. Name end Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Pertl. Enler the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ONE YEAR CANCER, TONSILS Examiner Due to (or es e consequence of): Examiner physician and s the burial-transit lew requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es a consequenca of): ettending pl for use es t signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DEEP VENOUS THROMBOSIS, LEFT LOWER EXTREMITY þ 24b. Were eutopsy findings evalleble prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? certificate has b 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stally filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Placa of Deeth (Check only one) To Hospitel: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? Certification: 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI completaly filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the ceuse(s) and manner stated. edicai 29a. Certifier 29b. Signeture end little of certifier 20s, License number 29d. Date signed (Month, Day, Year) MARCH 5, 1999 Hurra 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) DR AURORA TAN, M.D.--9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State MAR 1 0 1999 Registrar

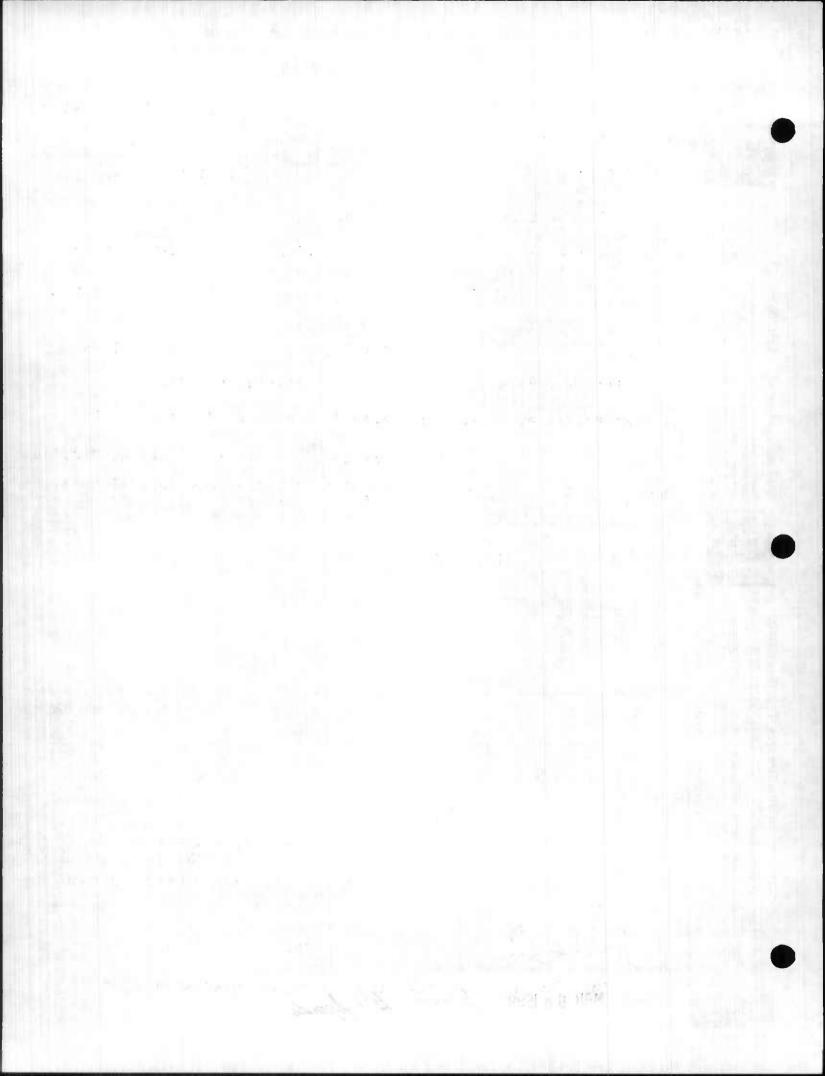


State of Maryland / Department of Health and Mental Hygiene 9 9275

Certificate of Death

Reg. No.

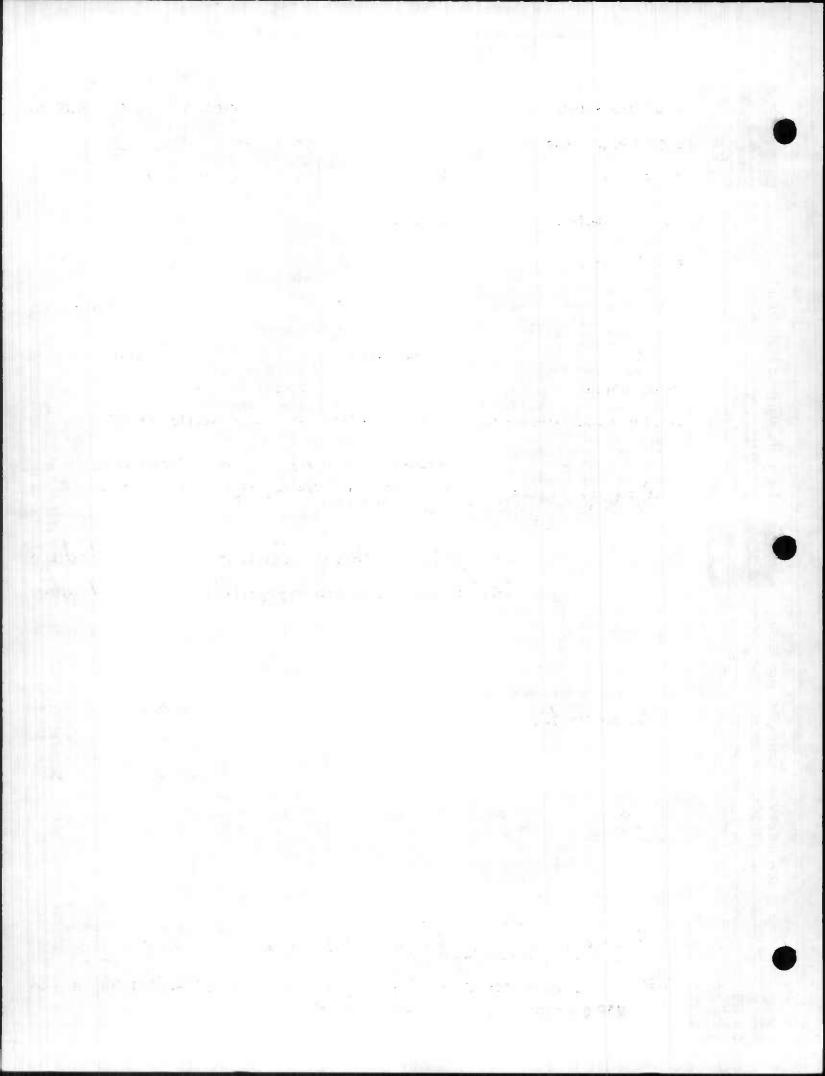
						Ce	rtificat	te of	Death			Reg. No.		2 12 10
Physician /Medical		. Decedent's Name	e (First, Middle, La	william	1 PETE	RSON	, JR		ш		2. Date of De Month MARCH	Day	Year 1999	3. Time of Death
Examiner	48		f not institution, give EMORIAL H		ber)					own, or Lo	cation of Deat	h 4c. Co	ounty of Death	
Funeral Director	2	Social Security N 218-96- sual Residence of	5152	Sex 7	. Age (In yrs.	last birthdey) 7 Yrs.	If Under Months			24 Hrs. Min.	8. Date of Bit (Month, De 04/0	th ly, Year) 8/81		place (State or Foreign ntry) y l a n d
se-f show refined at	10	M D	10b. County Dorche	ster	10c. Cit	y, Town or Lo		Hur	1 ock					10d. Inside City Limits 1 ☐ Yes 2 🛛 No
23ª or 2	6	0e. Street and Nur 5943 Hy	nson Ro	a d			10f. Zip	o Code	21643	3		-	ed St	
72 hours efter deeth with the Maryland naturel; or items 23s or 28s-f show areal Examiner must be notified at steel by Funeral Director	1	Marital Status     Marital Status     Never Marri     Widowed	ied 2 Married	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Date	es?		If Yes, spe	cify Cul	Hispanic Ori can, Mexical Specify:	n, Puerto	ecify Yes or No Rican, etc.)		Raca - Ameri Black, White pecify: B1	
		(Spec	15. Decedent's E			16a. Dece (Give	kind of wo	ork done	duning mos	t of worki	ing.	16b. Kind	of Business/Ir	ndustry
should be lied within 72 hours en and Mental Hygiena in marked other than "naturel", or imatic event, tre Medical Exam To Be Completed by F		Elementery/Seco	+	College (1-	4or 5+)		Deta		r		(E) . A4: ( II)		Deale	rship
should be til nd Mental H marked ott umatic ever To Be			(First, Middle, Last		n, Sr				1		y B.		mame)	
i and 2 sho Health and I em 27 is ma wher treum	1	9a. Informant's Na William	Peters	Type, Print) On, Sr	.(Fath	19b. Maili	ng Address	s (Stree	n SON	Roa	d, Hu	er, City or T rlock	own, State, Zi	21643
Pages nent of int: If it	20		position □ Cremation 3 □ 5 □ Other (Speci		ate	Place of Dispo emetery, cred	Ceme	ter ter	У			Pres		Maryland
permit. Pag Department Important: I sny Injury o once.	2	1. Signeture of Fu	chall 7.	Eskov	_	F	ramp 0 Bo	ton x 4	ess of Facili	kins eder	-Esko alsbu	w Fur	neral 1D 216	Home, PA
the deeth certificate be executed by the ettending physician end burbed for use as the burbetransit by sician/Medical Examiner	E SIN C	isease or conditions and its control of the control	nditions, nmediate orlying Injury	b		or as a consecutive as								
ires that the deeth cert signed by the ettendin d be detached for usa d by Physician/N	P	art II. Other algnif	lcant conditions	contributing to dea	th but not res	ulting In the u	inderlyling	cause g	iven in Part	l.	23b. Dld	tobacco us	s contribute	to the cause of death
det det											10	Yes 2	No 3□Pro	bably 4 Unknow
ew raques been 2 should								Ħ				en eutopsy ormed?	8	Vere autopsy findings vailable prior to ompletion of cause f death?
certificeta he rector, page												Ƴes 2□I	No 1	XOres 2□ No
		5. Was case reference examiner?		Hospital:	patient XX	'ER/Outpatie	nt 3 D	OA O	ther:		h <i>(Check</i> on <i>ly</i> me 5 □ Res		Other (Spec	i(v)
or Attending Phater the Color. After the in by the funeral artification:		7. Manner of Death 1 Naturel 2 Accident 3 Suicide 4 Homicide	h 5 Pending investigatio 6 Could not b determined	28e. Dete of (Month)	4 84 5	28b. Time of Injury 2 · 3	op <sup>M</sup>	28c. Inj W 1 [	uryat ork? ∐Yes 21)⊠	DNo 2	28d. Describe	how injury of	occurred (o	11000 :+
To the Hospital within 24 hours of To the Funeral is completely filled Medical Ce		9a. Certifier (Check only one)	1 Certifying Pt	ysician: To the b niner: On the bes and manne	is of examina	wledge, deet tion and/or In	h occurred vestigation	l et the t	ime, dete er oplnion, dea	nd plece, ath occurr	and due to the red at the time,	cause(s) ar date and pl	nd manner as eca, and due	stated. to the cause(s)
within comple								29d. Date s	signed (Month	, Day, Year)				
	20	Name and hou	num of moreon ward	completed cause	of death (Item	23a) /Tune	Print\		OCME			MARCI	H 7, 19	999
State		Name and address     Date filed (Mont	MARIO P	completed cause		Penn S		20		ore,	Maryla			199



State of Maryland / Department of Health and Mental Hygiene 00

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** IRENE ADA PRINKEY 6:00 pm MARCH 4 1999 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SACRED HEART HOSPITAL CUMBERLAND
If Under 24 Hrs. | B | r ALLEGANY If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1 □ M 2 🖾 F Yrs. 88 162-54-1611 18, 1910 Director Aug. Usual Residence of Decedent with the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Bedford Hyndman 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural", or Itema 23a or eny Injury or other traumatic avent, the Medical Examinat must be not by Injury or other traumatic avent, the Medical Examinat must be not be an end injury or other traumatic avent. RD 1 Box 61 15545 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Merried 2 □ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify λq 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Frank McFern Bertha Schroyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Ludwig--daughter 802 N. 9th Street; Connellsville, PA 15425 20b. Placa of Disposition (Name of cemetery, crematory or other pleca) 20c. Location - City or Town, Stete 20a. Method of Disposition 1X Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 Donation 5 DOther (Specify) Normalville Cemetery 03/08 Normalville, PA 21. Signature of Funeral Bervice Licenses 22. Name and Address of Fecility Scarpelli Funeral Home, P.A. for Brooks F.H. Cumberland, MD 21502 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only only cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Cardio my apath Examiner physicien end s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be axec P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): SBS - BSn jo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes WNo 3 Probably 4 Unknown signed t Division of Vital Records, by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen completion of cause of death? pege 2 s has 200 No 1 ☐ Yes 200 No 1 Yes certificate or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidenca 8 Other (Specify) 2 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) After 5 Pending investigation Injun Natural efter death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident n 24 hours efter der ne Funerel Directo bletely filled in by th 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner steted. To the Y within 2 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) D23774 Therer 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 912 SETON DR CUMBERLAND MD 21502 na LIVENGOOD mD 31. Date filed (Month, Day, Year) MAR 0 8 32. Registrar's Signature State FINE STA

Registrar



State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 8,1999 7:15 am Robert Lee Peterson Sr. 4a. Facility Nama (If not institution, give straet and number) 4b. City, Town, or Location of Death 4c. County of Daath Prince Georges Clinton If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 6 Sex 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 1√2 M 2□ F Months Days Yrs. December 25,14 Georgia 10b. County 10c. City. Town or Location 10d. Inside City Limits 1√ Yes 2 No Maryland Prince Georges Clinton 10f. Zip Code 10g. Citizen of What Country? 20735 U.S.A 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give X Year or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Navar Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 □ Divorcad Black no 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Skilled Labor Sugar Mill Refinery 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Griffin Peterson Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Straat and Number or Rural Route Numbar, City or Town, State, Zip Code) Brenda Williams/Daughter 6101 Plumway, Clinton Maryland 20735 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - Cify or Town, State Burial 2 Cremation 3 Removal from State
4 Donation 5 Othar (Specify) Washington Memorial Cem. March 13,99 Clewiston Florida 22. Name and Address of Facility ADAMS FUNERAL HOME P.A., AQUASCO MARYLAND 20608 23a. Part1. Enter the disease, or shock, or heart failure. List romplications that daused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, rily one cause on each line. Onset and Death failure congestive breart montzs. Due to (or as a consequenca of): Ord 1'orny lathy
Due to (or as a consequence of): Endstrye renal da Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Carrinome of 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of causa of daath? 24a. Was an autopsy performed? 1 Yas 2 ANO 1□Yes 2□No 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residance 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

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Completed

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Certification:

Medical

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certificate

Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certifice.

To the Vithin 2

filled in by

physician

The law requires that the death certificete be axecuted

Box 68760.

P.O.

Records,

of Vital

Division

**Physician** 

/Medical

**Examiner** 

Funerai

Director

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Hygiene.

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other 1

Director

Funeral

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altimore, Maryland 21215-0020

6101 Plumway 5. Social Security Number

263-26-4541

10e. Street and Number

11. Marital Status

Frank

6101 Plumway

12

20a. Method of Disposition

10a State

Usual Residence of Decadant

ician/Medical Examiner Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last Physi

Immadiate Cause (Final disease or condition rasulting in death)

25. Was case raferred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1 Dalatural 5 Pending Investigation

28a. Date of Injury (Month, Day Year) 6 Could not be determined

28b. Tima of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifian (Check only one)

2 Accident

3 ☐ Sulcide

4 Homicida

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and placa, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifiar

28e. Place of Injury - At home, farm, streat, factory, offica building, atc. (Specify)

D46478

29d. Date signed (Month, Day, Year) . 8-99

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

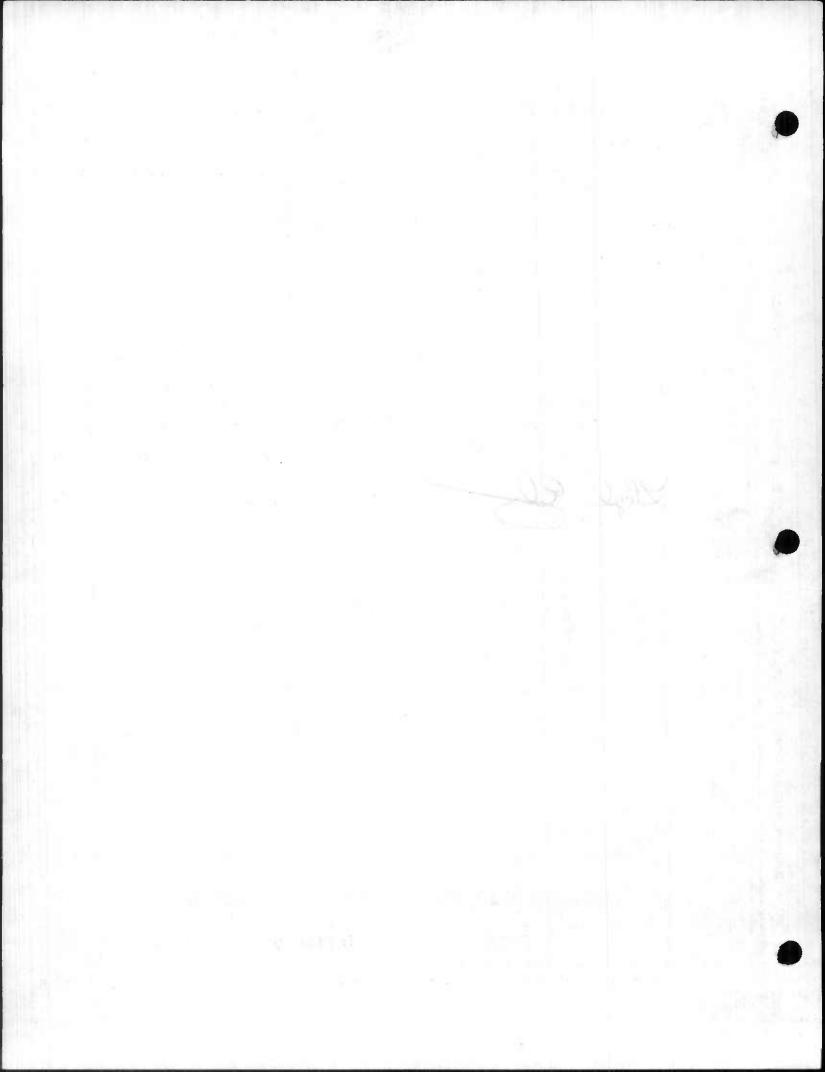
7501 Surratas Rd # 307. Chinton mp 20735 Suresh A. Patalinio. 31. Date filed (Month, Day, Year)

State Registrar

MAR 11 1999



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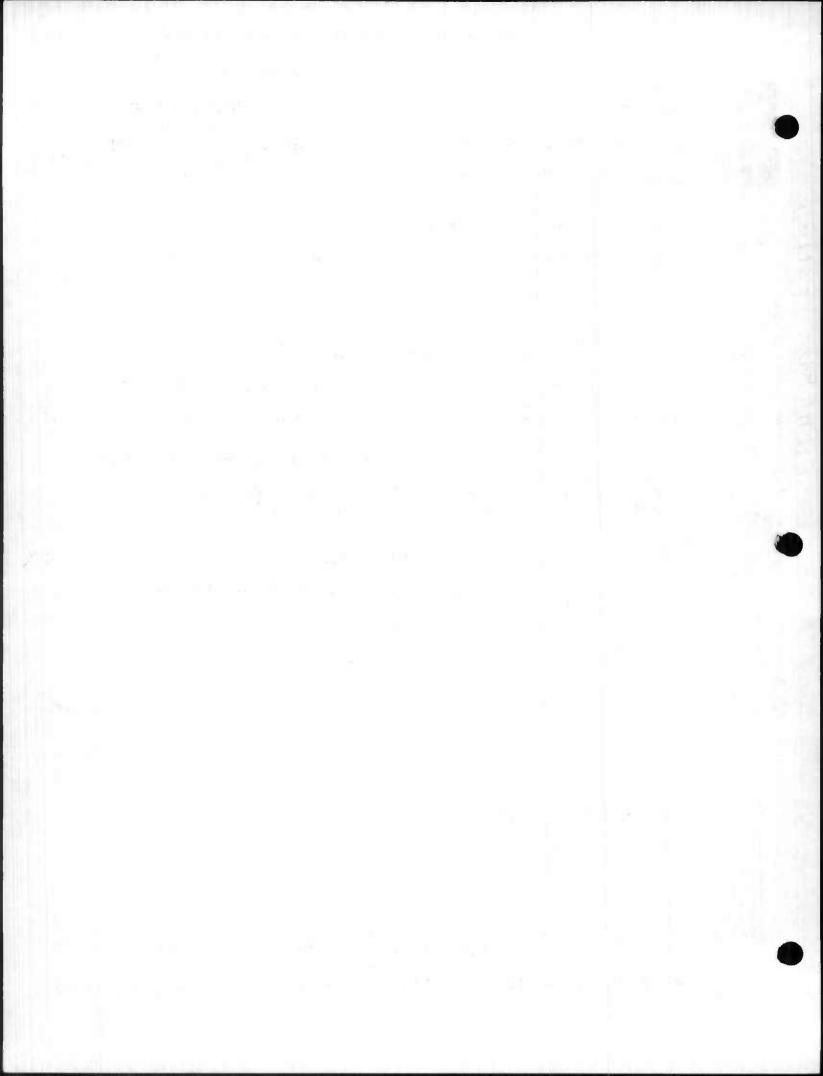
State of Maryland / Department of Health and Mental Hygiene

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o	as thet the death ce igned by the ettendi be datached for use	Physician/	Pert II. Other significant conditions of	ontributing to death but	t not resu	Iting In the under	ying cause (	given In Pert I.	23b. Dld	tobacco use co	ntribute to th	e cause of death?
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		-	30. Neme end eddress of parson who	completed cause of de	eth (Item	23a) (Tyne Print	1				-, 1	
			Monika G. Lee.				_	r #100 1	J. 1 J 4	M 1	1 0	0.600

State Registrar 31. Dete filed (Month, Dey, Year) MAR 1 1 1999

32. Ragistrer's Signeture

B. Sparke



State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Feb. 24, 1999 Clifford Long Parsons, Sr. 12:45 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Garrett 510 Hutton Road 0akland Birthplece (State or Foreign Country) If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 8. Dete of Birth (Month, Dey, Year) **Funeral** Min. Months Deys Hours 123 M 2□ F 236-28-1031 81 West Virginia Director May 9, 1917 Usuel Residence of Decedent with the Menylend 10c. City. Town or Location 10d. Inside City Limits 10e Stete 10b. County 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☒ No Directo 0akland MD Garrett 10e. Street end Number 10f, Zip Code 10g. Citizen of Whet Country? 21550 USA 510 Hutton Road Funeral deeth 12. Wes Decedent Ever in U.S. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Armed Forces?

1 Yes 2 No 1938

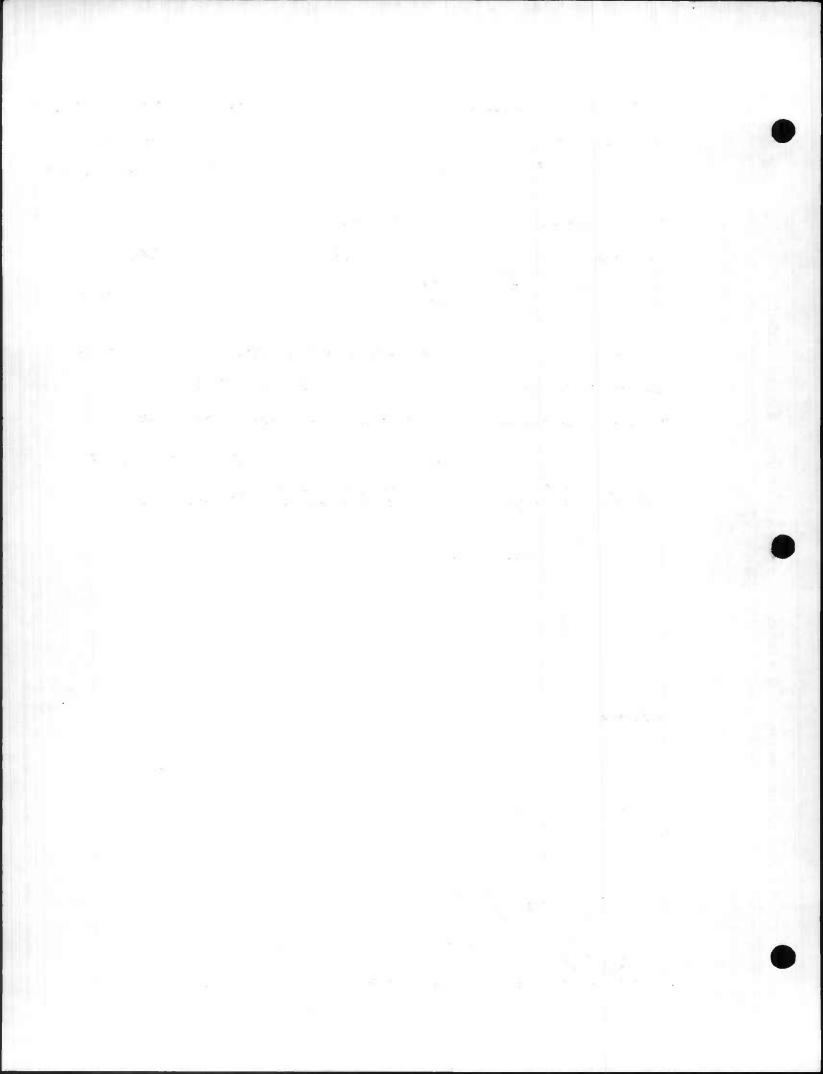
If Yes, Give Black, White, etc. permit. Peges 1 and 2 should be filled within 72 hours effer c Department of Heelift and Manial hygiene. Important: If item 27 is marked of any injury or other. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify by 1940 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) 9th Heavy Equipment Operator Coal Mining 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) Be Nora Avis Kelly Ira Lovelle Parsons 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 510 Hutton Road, Oakland, Md. Velva J. Parsons/Wife 20b. Pleca of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, Stete cemetery, crematory or other plece) 1 XBuriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Parsons, WV 2/27/99 Parsons Cemetery 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Stewart Funeral Home hum 32 S. Second St., Oakland, Md. 21550 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) colon cancer vears Examiner Due to (or as a consequenca of) Examiner law requires that the death certificate be executed -tren and Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting In deeth) Last Due to (or as e consequence of): -leinnd P.O. Box 68760. physician Physician/Medicai the Due to (or as e consequença of): 98 ettending esn 10 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown signed t emphysema Records, þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Was an autopsy performed? peed hes pege 2 ZEI No 1 T Ves certificate 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 € Residenca 6 ☐ Other (Specify) 2 1 Yes 2 No this funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Certification: After 5 Pending investigation Injury 1 Neturel To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 | Homicide Certifying Physician: To the Sest of my knowledge, death occurred et the time, date end piaca, end due to the ceuse(s) and menner es stated.

2 Indicate the time, date end piaca, and due to the cause(s) and menner estated. edical 29a, Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifi D23979 2/25/99 30. Name end endress of person who completed cause of deeth (Item 23e) (Type, Print) (0 Robert A. Goralski, M.D. 311 N. Fourth St Oakland, MD 21550 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture

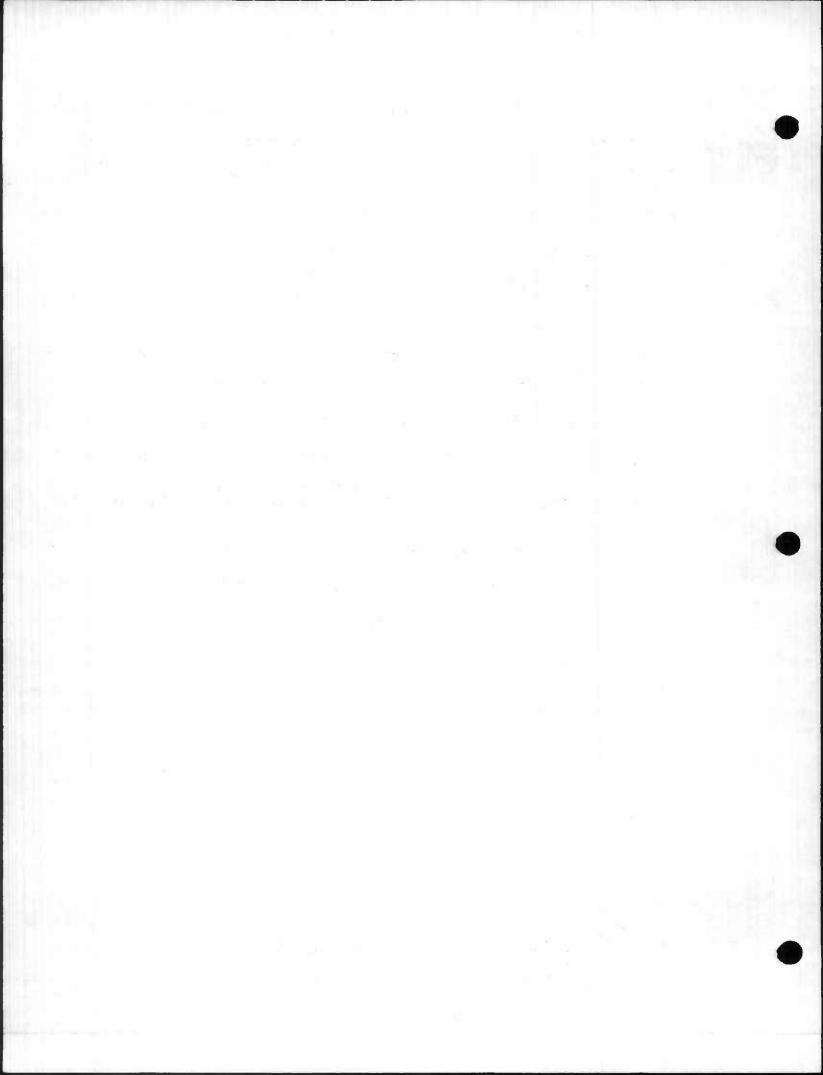
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Registrar

MAR - 8 1999

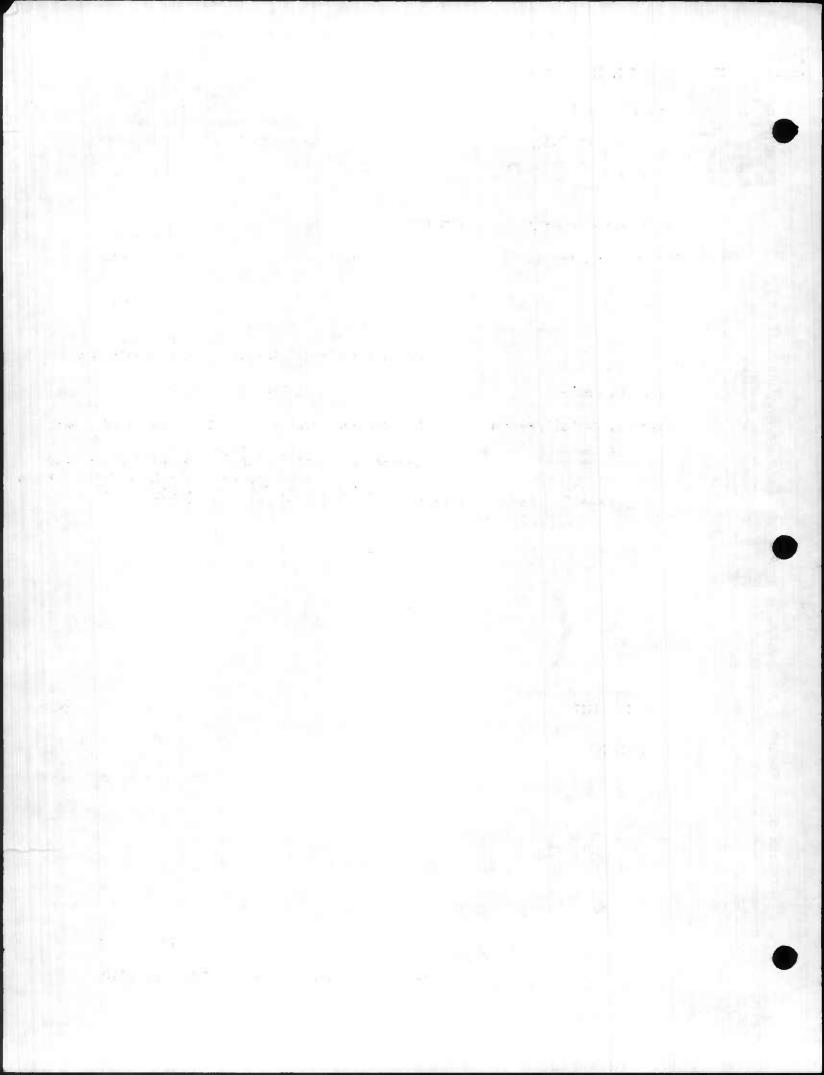


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allard Bay Ca	re Center				Camb	oridge		orches	ter
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	b. Cor	Dua to (or	f as a conseq	uance of):	y de	seas	C.		years.
entially list conditions, , laading to immadiata a. Enter Undarlying a (Disaase or injury nitiated avents ting in daath) Last	· Hy	pert	r as a consequence of as a consequence of a consequence o	roi	, *				years
	d								
. Other significant condition	na contributing to da	ath but not rasu	uiting in tha ur	ndarlying caus	sa givan in Part I.	23b.	Did tobacco use c	ontribute to	the cause of death?
							1□ Yes 2√No	3 Prob	eably 4 Unknown
						24a.	Was an autopsy performed?	con	ra autopsy findings illable prior to inplation of causa daath?
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/as casa refarrad to medical kaminar?	Hospital:					of Death (Chack	only one)		
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☐ Homicide datarm	buildir	ng, atc. (Specify	)			City	or Town, Stata)		
(Check only 2 Medicat I	g Physician: To tha Examiner: On tha ba and mann	sis of axaminat	ion and/or inv	astigation, in	my opinion, death	n occurred at the t	time, date and place	, and dua to	tha cause(s)
Signature and title of certifier	_	~~~		29c. L	cansa number		29d. Data sign	ed (Month, L	Day, Year)
) ul		Y		D	5298	7	3/	8 90	\
ame and address of person	who complated caus	a of daath (Item	23a) (Type, I	Print)		( M	70.5	Can	rton de
med	Dun	Taz-	105	Au	ron	0 /86	veer		many
tr	and address of persons  Med (Month, Day, Year)	med Dun	med Dawaz	med buraz 105	and address of person who complated causa of daath (Item 23a) (Type, Print)  Med Dusta 105 Au  ed (Month, Day, Year)  32. Registrar's Signatura	and address of person who complated causa of daath (Item 23a) (Type, Print)  Med Dust 105 Auror  and (Month, Day, Year)  32. Registrar's Signatura	and address of person who complated causa of daath (Item 23a) (Type, Print)  Med Dusta 105 Auror 105  and (Month, Day, Year)  32. Registrar's Signatura	and address of person who completed causa of death (Item 23a) (Type, Print)  med Duva 105 Amou Street  ed (Month, Day, Year)  32. Registrar's Signatura	med blusty 105 Amora sheet com



					Certifi	icate of	Death	1	Reg. No.	. 0	1281
Physician	1.	Decedant's Nama (First, Middla, Li						2. Data of Dea Month	ith Day	Yaar	3. Time of Death
/Medical		Wilbur T.	Pridgen						,1999	12000	9:30 am
Examiner	46	Facility Neme (If not institution, gi	va street and number)				4b. City, Town, or I				
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or 28a-fs be notified Director	11	De. Street and Number	1		1	Of. Zip Coda			10g. Citizen of V	Whet Count	ry?
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122		Loraine M. Harr	is		713 M	arlee	Drive Ro	cky Mou	nt, NC	2780	1
of Ham	21	Da. Mathod of Disposition			Place of Dispositio	n (Nema of	aca)	Data	20c. Location -	City or To	wn, State
nt: II		XX Burial 2 ☐ Cramation 3 [ 4 ☐ Donation 5 ☐ Other (Speci			ardens o			3/13/99	Rocky	Moun	t, NC
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	1	that Part! Entar tha disease, or conshider the shock or heart failure. List only	npiications that causa	d tha daat	h. Do not antar th	na moda of dy	ing, such as cardiac	or respiretory er	rest,	11, 14	Approximate
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RATHELL ITEMS	: #23 PART I	, II, 27 PEF	R MEO G769 3	3-24-99 W	RCertificate of	of Death		Reg. No.		C. Albertain		
	1. Decedent's Nam	na (First, Middle, Las	1)		CARCAL LITTLE		2. Data of De		W- ==	3. Time of Death		
Physician	Linda L	. Rathell					Month MARCH	06, 199	Year	11:15 AM		
/Medical Examiner		If not institution, give	street and number)			4b. City, Town, or I	1					
Examiner		RAGUT AVE				DOCKNITT	F	10/24/2	GOME	S.A.		
	5. Social Sacurity N			a (In yrs. last I	hirthday) If Under 1 Ya	ROCKVILL nar If Undar 24 Hrs.	8. Date of Bir					
Funeral Director	218-48-7	16	DM <b>≱©</b> XF	51	Yrs. Months Da	ys Hours Min.	(Month, Da	ıy, Year)		place (State or Foreign otry)		
	Usual Residence o			71			June 20	), 1947	Mar	yland		
land w	10a. Stata	10b. County		10c. City, To	wn or Location				1	0d. Inside City Limits		
Many 1 sh	Manufond	Montoomo		Doolrand	1110					1 ¥ Yas 2 □ No		
vith the Mar or 288-1 s or Director	10e. Street end Nu	Montgome:	Ly	Rockvi	10f. Zip Cod	la		10a Citizen of	What Cour	ntry?		
1020  urs after death with the Maryland ral', or items 23s or 28s-1 show Examiner must be notified at by Funeral Director								10g. Citizen of What Cour				
O iffer death v r flems 23s		agut Aven		Francis III O	2085		if Va Na	United	State			
er de	11. Marital Status		12. Was Decedant Armed Forces?		If Yes, specify C	of Hispenic Origin? (S Juban, Mexican, Puert	o Rican, atc.)	etc.				
-0020 hours after hural; or fre Examine ed by Fu	3 Widowed	ried 2 Married	1 ☐ Yas 2 📉 If Yes, Give	No	1□ Yas 21XI	No Specify:		Specil	y:			
Doug Pour	3 D WIDOWED		Year or Datas:	1.40	sa. Decedent's Usual Oc			401 101-4-40	Whi			
72 72 et	(Spec	15. Decedent's Edu cify only highest grad		16	lusiness/în							
Baltimore, Maryland 21215-0020 permit. Pages 1 end 2 should be filed within 72 hours at Department of Health end Mental hygiene. Important: If them 27 is marked other than "natural", or any injury or other traumentic event, the Medical Examples.  To Be Completed by F	Elementery/Seco	ondary (0-12)	College (1-4or 5		life. DO NOT use rea			Montgon	-			
Co Co	17 Fathada Mari	/First Adiddte 1	33	F	Administrat:				overn	ment		
be first Hall Hall Hall Hall Hall Hall Hall Hal	17. Fathers Nama	(First, Middle, Last)				18. Mother's Nar	ne ( <i>First, Middl</i> e,	, Maideri Sumai	ne)			
yla buld Men Men Men To	Edward W	. Rathell				Barbara	Richard	dson				
Par end end se m	19a. Informant's N	ame/Relationship (T)	ype, Print)	15	9b. Meiling Address (Str	eet and Number or Ru	iral Route Numb	er, City or Town	, Stete, Zip	Code)		
end salth	Edward W	. Rathell	/Father	3	303 Farragu	gut Avenue, Rockville, Maryland 208						
or Heart	20a. Method of Dis			come	of Disposition (Name of tery, cremetory or other	metory or other place)						
Page ent. H						omery Crematorium, Inc. Bethesda, Marylan						
alti.	21. Signature of Fu	meçal Service Licens	be	1101102	22. Name and Address of Facility Robert A. Pumphrey Funeral 1							
	1	T.OE	) .		Rockville	e, Inc. 30	0 West 1	Montgome	ery A	venue		
(b)	1/4	will.	serry.	M00803	Rockville	e, Marylan	d 20850	0-2805	-			
	shock, or hea	me disease, or comp art failure. List only o	na cause on each li	d the death. Di	o not enter the mode of	dying, such as cardiac	or respiratory e	rrest,		Approximete Interval Between Onset and Death		
Physician										Onset and Death		
/Medical Examiner	Immediate Cause disease or condition	(Final	a	CARDIA	C HYPERTROPHY							
The second second	resulting In death)			Due to (or es	e consequence of):							
P # C			h									
60, be executed cian and buniel-transit	Sequentially list co	enditions,	D	Due to (or as	a consequenca of):							
60, be ext ician s buriel	Sequentially list co if any, leeding to in cause. Enter Under	nmediate erlying							1			
6876 ifficete by physic as the bealca	Cause (Disease or that initiated events resulting in death)	S	С.	Due to (or as	a consequence of):							
	rosulting in Godiny	Lusi							-			
Box eath cert for use			d									
Mark CT 4	Part II. Other slonif	ficant conditions co	ntributing to death b	ut not resulting	in the underlying cause	given in Part I.	23b. Dld	tobacco use co	ontribute to	the cause of death?		
P.O. at the of by the eleche		OBESITY					1□	Ves 2□No	3□ Pro	bably 45 Unknown		
		0023111										
ords requires seen sign hould be							24e. Was	an eutopsy	24b. W	ere autopsy findings		
I Record The law require sate hes been single page 2 should Completed	DEPRES	SSION					perto	ormed?	CC	allable prior to impletion of causa		
Rec s law hes b									of	death?		
al R							1/2	Tes 2 No	N N	⊈Yes 2□ No		
Division of Vital Records, to Attending Physician: The law requires thater death.  Director: After this certificate has been signed in by the funeral director, page 2 should be entification: To Be Completed by	25. Was case refer examinar?		Utomite!		ī		ath (Check only	one)				
of \Physic of this of this of the ral direction of	1 ☐ Yes 2 ☐	140	Hospital:		Juipellent 3L DOA		lome 5 💢 Resi			y)		
ng P Rer t	27. Manner of Deat 1 DNeturel	th 5 Pending	28a. Date of Inju (Month, Da	y Year) 28b	Time of 28c. In 1	njury at Work?	28d. Describe	how injury occu	rred			
Division or Attending I after death. Director: After din by the fune ertification	2 Accident	investigation			M 1	1 ☐ Yes 2 ☐ No						
Vis An	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Plece of Injuding etc	ury - At home,	farm, street, factory, offi	ica	28f. Location ( City or To		ber or Run	al Route Number,		
Division of the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1			banding, bu	an (Specify)			5, 5 , 5	,/				
Hospital Puneral Puneral Rely filled	29a. Certifier				ge, deeth occurred et the							
he Hosplin 24 hours he Funer pletely fill edical	(Check only one)	2 Medical Exami	ner: On the basis of and manner sta	f examination e ated.	end/or investigation, in m	ny opinion, death occu	rred et the time,	date and placa,	, end due t	the cause(s)		
To the Hospital within 24 hours To the Funeral completely filled	29b. Signature and	title of certifier			29c. Lic	ense number		29d. Data signa	ad (Month,	Day, Year)		
- SFO	N		10/			OCME		MARCH (	07, 19	999		
- ^/	Lu	mus/	Christe	W								
17	30. Name and addr	ress of person who co	ompleted cause of d	leath (Item 23a	(Type, Print)	eet, Balti	more, Ma	arvland	2120	1		
	knni	s Chu	te mus			-,		1				
State	31. Date filad (Mon	MAD 0 8 10	32. Registro	ar's Signature	1. 1							

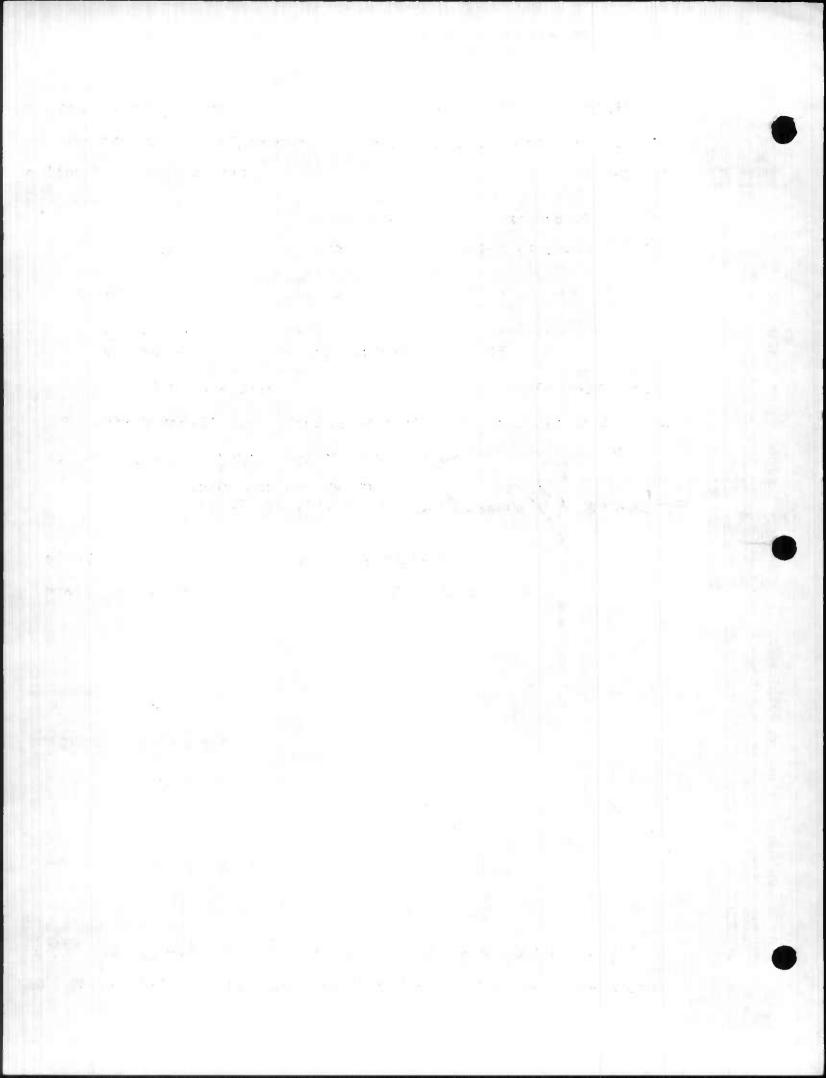


State of Maryland / Department of Health and Mental Hygiene 9 9283

PILAR P. RICHARDSON  MARCH MAR		Certificate of D	Death	Reg. No.					
PILAR P. RICHARDSON  As Feelily News (first simulating betweel and country) gets read and number)  Shady Grove Adventist Hospital  Shady Grove Adventist Hospital  Rockville  Rockrille  Rockville  Rockville  Rockville  Rockville  Rockville  Ro		Decedent's Name (First, Middle, Last)			3. Time of Deet				
46. Feelily Name (Infort institution, give street and number)  40. Sp. Town, or Location of Beeth 100 NOTGOMERY  Anady Grove Adventist Hospital Rockville		PILAR P. RICHARDSON							
5. Social Security Number 247-33-3253 10M 28F 38 yrs. 39 yrs. 30 yrs.			b. City, Town, or Location	of Death 4c. County	of Deeth				
100   100		Shady Grove Adventist Hospital			TGOMERY				
Montgomery    10s. Since and Number   10s. Since and Since and Number   10s. Since and Sin		247-33-3253 1 M 2 F 38 Yrs. Months Days	Hours Min. 8. Dat	e of Birth onth, Day, Year) 3.28,1960	9. Birthpiece (State or For Country) S. Carolin				
MD Montgomery Silver Spring 100, Citizen of Whet Country 30.28 Shanandale Drive 20904 103, Citizen of Whet Country 11 Market Status 11 Market					10d. inside City Lir				
10. Street and Number   30.28 Shanandale Drive   20.90.4   100, Citize of White Country?   10.50 people   10.	5		a		1 ☐ Yes 2 🔀				
17. Fether's Name (Pirst, Micola, Last)   18. Mother's Name (Pirst, Mode on Sumane)   19. Mother's Name (Pir	Direct	10e. Street and Number 10f. Zip Code							
17. Fether's Name (First, Micale, Last)   18. Mother's Name (First, Made and Sumanne)   19. Mailing Address (Street and Number on Fund Flourish Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number on Fund Flourish Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number on Fund Flourish Name of Fund Flourish Na	by Funera	1 Never Married 2 Married 1 Yes 2 No		etc.) Biacl	k, White, etc.				
Second   Comparison	mpleted	(Specify only highest grede completed) (Give kind of work done done of life. DO NOT use retired)	luring most of working	Montg.	Co.				
Leroy Richardson   Jessie Goodwin   Jessie Goodwin   Jessie Goodwin   Jessie John   Jessie Goodwin   Jessie John   Jessie Goodwin   Jessie John   Jessie J	ပိ								
19a. Informent's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20   20e Method of Disposition   20e Method   20	Be								
Veader Boyd (Sister)   3028 Shanandale Dr., Silver Spring, MD	1				State, Zip Code) 2 0 0				
20c Method of Disposition   20c Place of Disposi									
Perf II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I.   23b. Did tobacco use contribute to the cause in part of several property of several									
22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A.  ROCKUILLE, MD 20850  23a. Part Enter the chiese or conductions the caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, inferral Bet Onset and inferral Bet Death Infer				/99 Alexa	ndria. VA				
Immediate Cause (Fine)		SNOWDEN ROCKVILL	FUNERAL HO	350					
Due to (or es e consequence of):    Multiple Myeloma		immediate Cause (Fine)	g, such es cardiac or respii	ratory errest,	interval Between Onset and Death				
Sequentially list conditions, at eny, leading to immediate course. Enter Underlying to immediate course. Enter Underlying that initiated events resulting in death) Lest   Due to (or as e consequence of):    Due to (or as e consequence of):	r	1 resulting in deeth)			weeks				
Cause (Disease or injury in ideath) Lest  Due to (or as a consequence of):   اةِ ا				Vears					
Due to (or as e consequence of):    Due to (or as e consequence of):	Exami	0.			rears				
24a. Was en autopsy performed?  24b. Were eutopsy available prior completion of cord deeth?  1	2	resulting in deeth) Lest  Due to (or as e consequence of):							
24a. Was en autopsy performed?  24b. Were eutopsy: available prior completion of cord deeth?  1	Sician	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Pert i. 23	23b. Did tobacco use contribute to the cause of de					
25. Was case referred to medicei exeminer?  1   Yes   2   No	y Phy			1□ Yee 2⊠ No	3 Probably 4 Unkn				
25. Was case referred to medice: exeminer?  1   Yes   2   No  27. Menger of Death 1   Naturei   1	pieted b	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	24		24b. Were eutopsy findin- available prior to completion of cause of deeth?				
25. Was case referred to medice: exeminer?  1   Yes   2   No	TO.			1□ Yes 3□ No	1 ☐ Yes 2 ☐ No				
1   Yes   2   No	0		26. Place of Death (Chec	k only one)					
28e. Date of injury at Work?   Nature  28d. Describe how injury occurred	2	Hospital:	er: 4□ Nursing Home 5	☐ Residence 6 ☐ Othe	er (Specify)				
29a. Certifier (Check only one)  Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end manner as stated.  Description of the desired for the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.	Medical Certification: To	Accident investigation M 1 7	(7	escribe how injury occurr	ed				
29a. Certifier (Check only one)  29a. Certifier (Check only one)  Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  20a. Certifier (Check only one)  Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		determined   200. Placa of injury - At nome, ferm, street, rectory, office	28f. Lo Cit	cation (Street end Number y or Town, State)	er or Rural Route Number,				
		(Check only 2 Medicat Examiner: On the basis of examination and/or investigation, in my op	e, date end piece, end due pinion, deeth occurred at th	e to the cause(s) end ma te time, date and place, a	nner as stated. and due to the cause(s)				
D 1/1 / 1 101	Z	29b. Signature and title of certifier 29c. License	number	29d. Dete signed	(Month, Dey, Year)				
1 1 MA COVY, MD D4 + 1075 MARCH OS 19		Drug Mr Corny, MD D4	7093	MArch	05 1999				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)		30. Name and address of person who completed cause of death (Item 23e) (Type. Print)		1111011	1 /				
Martin McGreivy, M.D. 9701 Medical Center Dr., Rockville, MD 2		Martin McGreivy, M.D. 9701 Medical  31. Date flied (Month, Dev. Yeer)  32. Registrer's Signeture	CELLCET DI	., ROCKVI	LIC, MD Z				

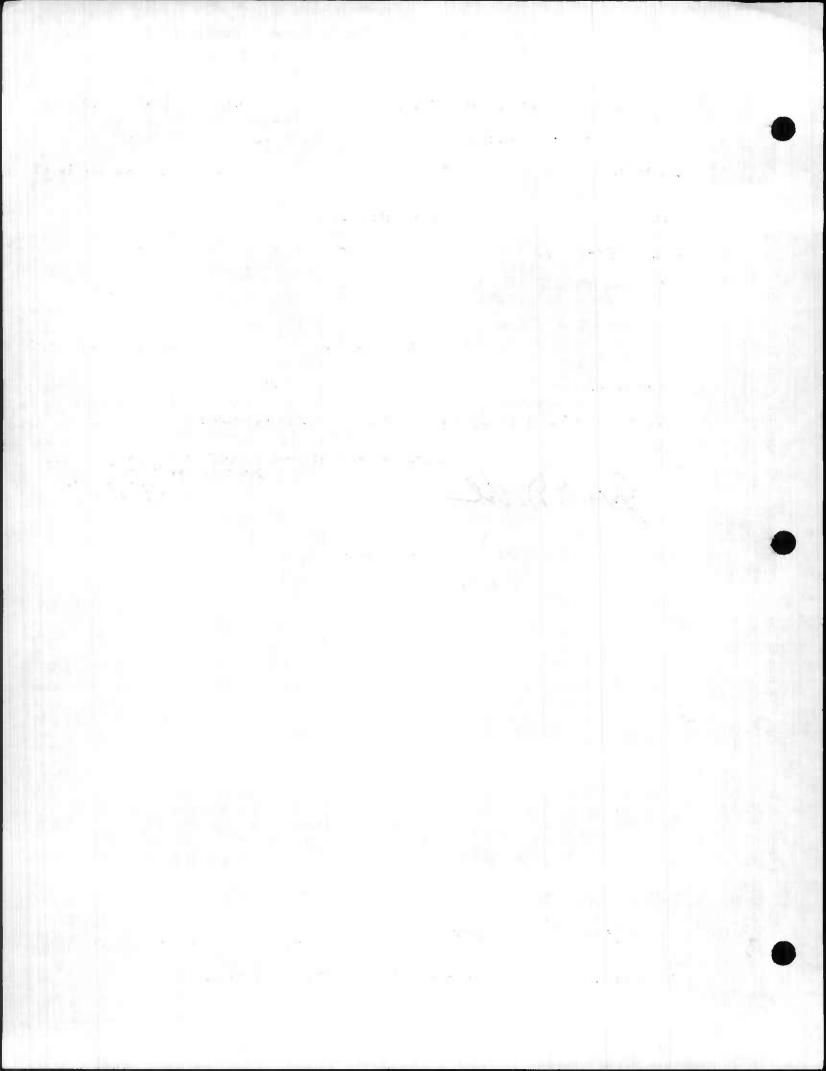
DHMH 16 Rev 6/95

Registrar



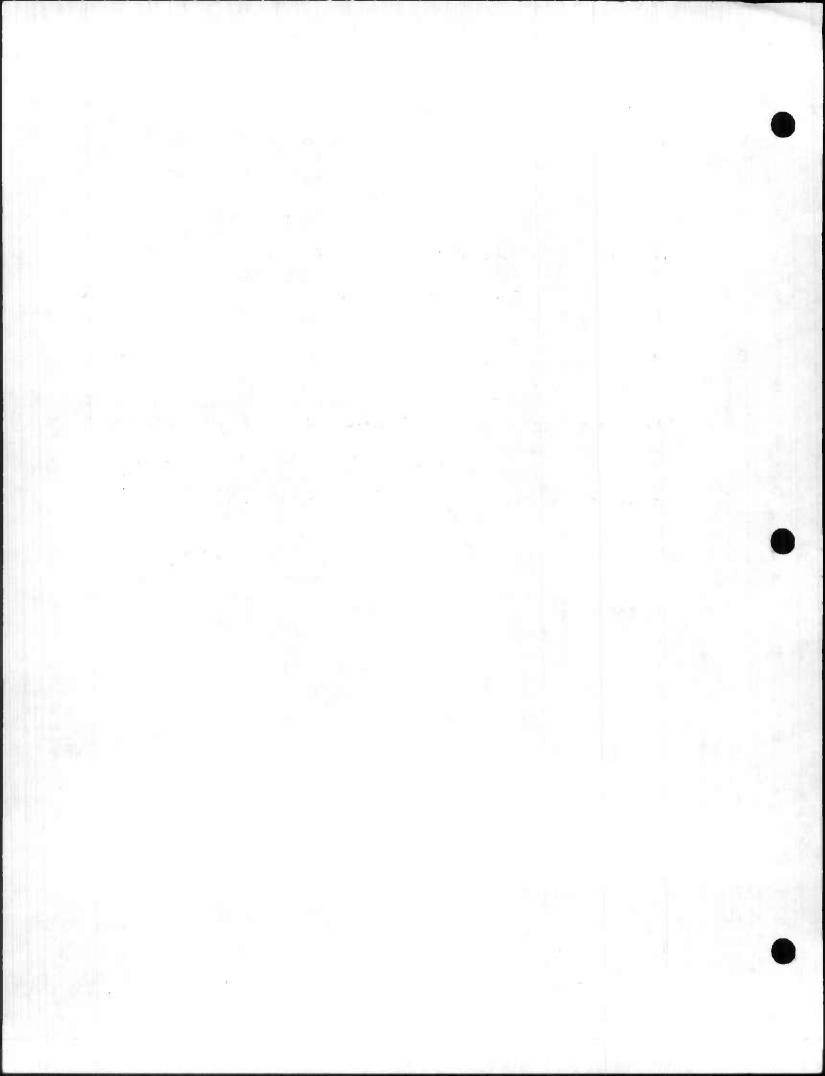
State of Maryland / Department of Health and Mental Hygiene 9 09284

[ net]		00	runcat	CUI	Death			Reg. No.				
Last)	E E S						2. Date of De Month	ath Day	Year	3. Tin	ne of Death	
eresa Rie	ster,	7.H.M.		14			March	3, 19	999	12:3	30 AM	
give street and numbe	r)				4b. City, Tov	wn, or Lo	cation of Deat	h 40. C	County of Death	1		
is Hospic	е											
. Sex 7. / 1 □ M 2 ☒ F			Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bir (Month, Da Nov. 2.	19, Year)	9. Birth Con 16 Loui	placa (St intry) SVII:	Le, KY	
	10c. City	y, Town or L	ocation							10d. insk	le City Limits	
e	W	ashing	eton.	D.C						110	Yes 2□No	
								10g. Citize	en of What Cou	intry?		
W.			2	2000	7				USA			
12. Was Deceder Armed Force 1  Yes 2 & It Yes, Give	No No					gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		Black, White	, etc.	n,	
		16a. Dece	dent's Usua	al Occur	pation			16b. Kin	d ot Businass/I	ndustry		
grade completed)		(Give	DO NOT us	rk done se ratire	during most							
College (1-40 2	r 5+)						Roman Catholic Church					
ist)					18. Motha	r's Nama	(First, Middle, Maiden Surname)					
						Clar	a Cami	11e				
(Type, Print)		19b. Mail	9b. Mailing Address (Street and Num			r or Rura	al Route Numb	er, City or	Town, State, Z	ip Coda)		
es McNabb/	superi	or 1	500 3	5th	St. N	.W.	Washin	gton.	D.C. 2	20007		
20a. Method of Disposition  120 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)												
	0					Com	Mar 5	0.0 1.1	lachinat	-02	D C	
	Get	orgeto 2	2. Name an	d Addre	ass of Facility	v De	Vol Fur	eral	Home	.011,	D.C.	
Washington, D.C. 20												
immediate Cause (Final disease or condition resulting in death)  Dua to (or as a consequence ot):  Arteriosclerosis  Sequentially list conditions, if any, leading to immediate and consequence of):  Due to (or as a consequence of):												
b												
c	Due to (or	resa conse	quenca ot):									
d												
contributing to death	but not resu	ulting in the u	underlying c	ausa giv	ven in Part t.		23b. Dld	tobacco u	iae contribute	to the ca	use of death	
Part ti. Other significant conditions contributing to death but not resulting in the underlying causa given in Part t.									No 3□Pr	obably	4⊠Unknov	
										vailable p completion	rior to	
							1 🗆	Yes 2X	No 1	Yes	2 No	
						of Deat	h (Check only	one)				
Hospitai: 1 ☐ inpa	tient 2 🗆	ER/Outpetie		<i>/</i> ^	4667 140	rsing Ho	me 5□Res	idence 6	☐Other (Spec	city)		
28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?  1 Yes 2 No could not be							28d. Describe	how injury	occurred			
detarmined										Number,		
29a. Certifier (Check only one)  29a Certifier (Check only one											use(s)	
aminer; On the basis				29c. License number								
aminer: On the basis and manner			290	. Licens	se number			29d. Date	signed (Monti	n, Day, Ye	ar)	
aminer; On the basis			290		se number				3, 199		ar)	
aminer: On the basis and manner	stated.		, Print)	D 1	15504	um,		March			er)	
tion of the state	Education rade completed)  College (1-40 st)  Colle	TIS Hospice  Sex 1 M 2 F 7. Age (In yrs. 82  10c. City  W.  12. Was Decedent Ever in U, Armed Forces? 1 Yes, Give Year or Dates:  Education Irrade completed)  College (1-4or 5+)  2 St)  (Type, Print)  ES McNabb/super:  Crype, Print)  ES McNabb/super:  Crype, Print)  Es McNabb/super:  Armed Forces?  I Yes, Give Year or Dates:  Education Irrade completed)  College (1-4or 5+)  College (	TIS Hospice  Sex   Town or Let   Sex   Sex	Sex 10 M 2 M F	Sex   1	Timon  Sex 10. Regilings last birthday) 10. City, Town or Location Washington, D.C.  10. Zip Code 20007  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, City Yes, City Yes, City College (1-4or 5+) 20. Place of Disposition (Name of Comeleny, Cremetery, Cremetery	Timonium  Sex	Timonium  Sex   Table   Table	Timonium  7. Age (In yrs. lest birthday)   # Under 1 Year   # Under 24 Hrs.   8. Date of Birth (Month)	Timonium  Baltimore Sax   T. Age (in yrs. lest birthday)   H. Under 1 Year   H. Under 24 Hrs.   B. Date of Birth   Park   Month, Day's   Month   Day's   Hours   Min.   Month, Day's   Park   Month, Day's   Month   Day's   Hours   Min.   Month, Day's   Park   Park   Month, Day's   Park   Park   Month, Day's   Park   P	Second   Control   Contr	



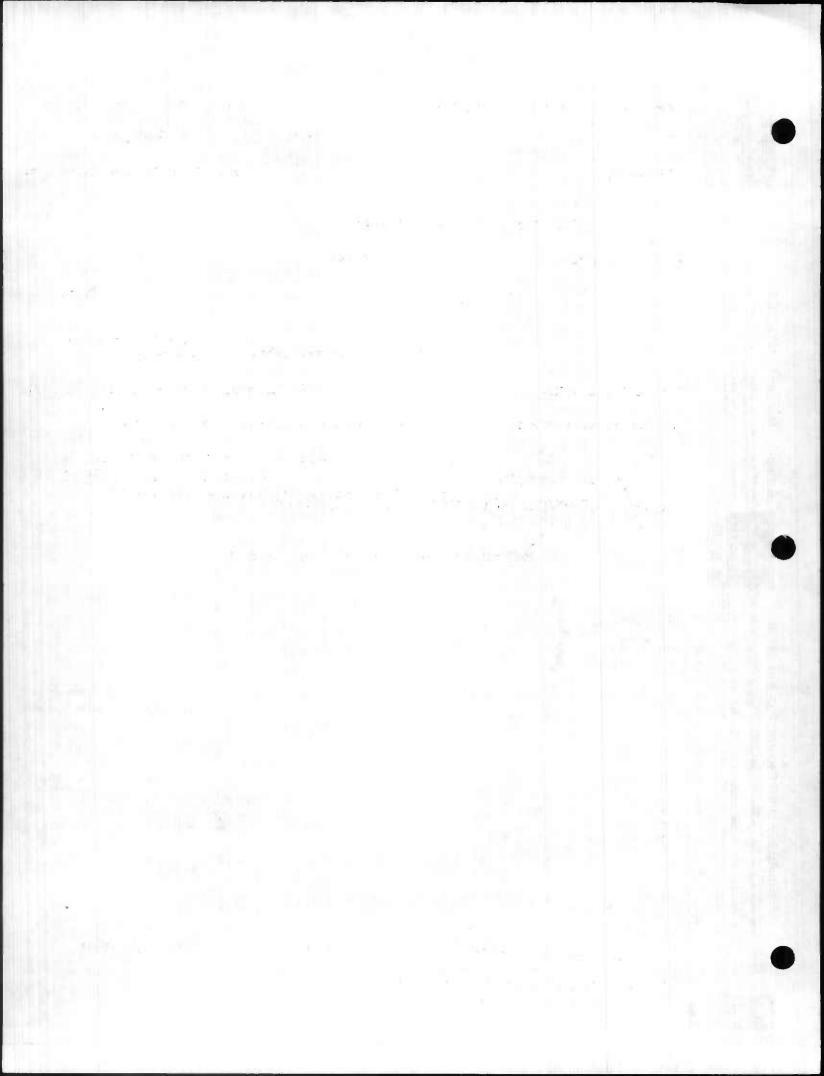
State of Maryland / Department of Health and Mental Hygiene 9 9285

			Ce	rtificate of	Death			Reg. No.	U.	200
	1. Decedent's Neme (First, Middle, Li	ist)					2. Date of De			3. Time of Death
Physician	William Denny	Rober	rts				Month March 3	. 1999	Year	2:00 PM
/Medical Examiner	4a Facility Neme (If not institution, gir				4b. City, To		ocation of Death		of Death	2.00
LAdminier	2388 Glenmont Ci	rcle. Ant. #10	6		Whea	ton		Maryla	nd	
Freezest		Sex 7. Age (In yrs.		If Under 1 Year	If Under		8. Date of Birt	h		lace (Stete or Foreign
Funeral Director	213-30-7001	1⊠M 2□F 56	Yrs.	Months Days	Hours	Min.	Dec. 3,	y, Year)	Coun	
pu a	Usuel Residence of Decedent  10a. Stete 10b. County	10c. Ci	ity, Town or Lo	ocation					1-1	0d. Inside City Limits
within 72 hours after death with the Maryland ens. Then "natural", or items 23s or 28s-1 show the Maries Examiner must be notified at Displeted by Funeral Director	MD Montgom		E ALVIE		neator	1	1100			1 ☐ Yes 2 ☒ No
# 22 P	10e. Street and Number			10f. Zip Code				10g. Citizen of V	What Coun	itry?
b wi	2388 Glenmont Ci	rcle, Apt. #10	6	209	902			USA		
fler death v	11. Meritel Stetus  1 ☐ Never Married 2 ☐ Merried	12. Wes Decedent Ever in L Armed Forces? 1 ☑ Yes 2 ☐ No	J,S. 13.	Wes Decedent of I If Yes, specify Cub	Hispanic Or an, Mexica	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)		e - Americ ck, White,	etc.
n 72 hours aft netural, or necession	3 ☐ Widowed 4 ☑ Divorced	If Yas, Give 60-7 Yeer or Detes:	9	1 ☐ Yes 2 🔀 No	Specify:			Specify	Whi	Lte
ed within 72 hours al Sygiena. Ser than "natural", or rt, the fleuceal Exam Completed by I	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	durina mos	t of work	ing	16b. Kind of Bo	usiness/Inc	dustry
e filed within the than vant, train the Se Comp	Elementary/Secondery (0-12)	College (1-4or 5+)		hanic	-5/			Automo	hile	
Pos	17. Father's Neme (First, Middle, Last	)	1100	nanze	18 Moth	ar's Name	a /Firet Mirklio	Maiden Suman		
ntal Hygen avant, avant, Be C	William O. Robe						Wallac		,0)	
2 should be fi and Mental It is marked of reumatic avan			401 44 111						0	
d 2 should be file th and Mental Hy 7 is marked othe treumatic avent	19e. Informent's Neme/Reletionship			ng Address (Street						
CENL	Carol A. Wood/Fr			Glenmont of Osition (Name of	Circ	ile,				MD 20902
	20e. Method of Disposition  1 XBuriel 2 Cremetion 3	Removel from State	cemetery, crea	metory or other pla Nationa			Date 3 / 0 / 0 0	20c. Location -		
rtand njury	4 Donetion 5 Other (Speci			2. Name and Addre				Arling		
permit. Pages Department of Important: If if any Injury or once.	Property Co	Emsen	H	ome, Inc.	. 500	Uni	versity			
	23a. Pert1. Enter the disease, or com shock, or heert feilure. List only	plicetions thet caused the						rest,	1	Approximete
Dhysician	shock, or heert feilure. List only	one ceuse on each line								Interval Between Onset end Deeth
Physician /Medical	Immediete Ceuse (Finei	0							t	
Examiner	diseese or condition resulting in death)	a. METASTAT Due to (	100	ANCER	TO	THE	LIVE	R.	- 1	
1		Due to (	or as a consec	quence of): PR	umat	ey c	ANCER	SITE N	TOL	8 weeks
axecuted in and intransit		b						KNOU	~	
certificate be axecuted nding physician and use as the burial-transit nAMedical Examir	Sequentially list conditions, if any, leeding to immediate	Due to (	or es a consec	quence of):					t	
g physician a as the burial	cause. Enter Underlying Cause (Diseese or Injury that initieted events	C							i	
ficate be physicia ss the bur edical	that initieted events resulting in death) Last	Due to (d	or es a conseq	quence of):					i	
N See N		d							i	
attending por stending por see as significant was as significant was as significant was significant with the second secon		<u>.</u>							1	
the a hed for y sic	Pert II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause gi	ven in Part	1.	23b. Did 1	obacco use co	ntribute to	the cause of death?
4 66 4	CHRONIC	OBSTRUCTIV	E PUI	MONAR	y Di	SEAS	E 10	Yes 2 No	3 Prol	bably 4 Unknown
signed d be del					1				T a.e	
The law requinitate has been single 2 should Completed								an autopsy med?	av	ere autopsy lindings allable prior to mpletion of cause
has by ye 2 s										death? NA
The I							101	res 2 No	10	Yes 2□ No
certificate rector, pag	25. Wes case referred to medical				26. Place	e of Deat	h (Check only o	ne)		
	axaminer? 1 ☐ Yes 2 ② No	Hospitel: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Ot	her: 4 Ni	ursing Ho	me 5 Resid	dence 6 Oth	er (Specif	y)
g Physer this seral d	27. Manner of Deeth	28a. Dete of Injury (Month, Dey Year)	28b. Time o	f 28c. Inju	Yat N	IAL	28d. Describe I	now injury occur	red	
atto	1 2Neturei 5 ☐ Pending 2 ☐ Accident investigatio		Injury	M 10	Yes 2	No		NA		
lal or Attanding P is after death.  al Director: Attent ed in by the funer:  Certification:	3 Suicide 6 Could not be determined	8 Ope Diese of Leives At h	ome, larm, str				28f. Location (S City or Tox	Street and Numb	oer or Rura	I Route Number,
S after of in Cert			.,,					.,,		
To the Hospital or Attanding within 24 hours after death.  To the Funeral Director: After completely filled in by the fune Medical Certification	29a. Certifier (Check only one) Certifying Pt	nysician: To the best of my kno niner: On the basts of examine and menner steled.	owledge, death etion end/or in	n occurred at the ti vestigation, in my	me, date an opinion, dea	d place, ith occur	and due to the red at the time,	cause(s) and me date and place,	enner as si and dua to	tated. the cause(s)
o the omple omple	29b. Signature and ofte of certifier	and mornior groups.		29c. Licens	se number			29d. Date signe	d (Month,	Day, Year)
F 3 F 8	D 111 8					88-		March		
511	441-43	200			2-0			THUYCH	2, 1	111
	30. Neme and address of person who			Print)	JAI	ALA	VAI Y	MEDICA	41 0	ENITER
	UPENDRA F 31. Dete liled (Month, Day, Year)	HEGDE N 32. Registrer's Sign		NATIOI	BI	TH	ES DA	MARY	LAN	ENTER
State Registrar		199 Separa	B.	Louis	61					



State of Maryland / Department of Health and Mental Hygiene 9 09286

			C	ertificate o	f Death		Reg. No.	0.26.00
Physician /Medical	1. Decedent's Name (First, Middle, L AWTHOWY CORW		5			2. Date of Month	of Daath Day	Year QQQ 2218
Examiner	4a Fecility Nama (If not institution, g				TAKO	own, or Location of I		y of Death GoMGK
Funeral Director	5. Social Sacurity Number 6. 579–14–9995  Usual Rasidance of Decedant	Sex 7. Age (In y	rs. last birthda Yrs.	y) If Under 1 Yes Months Day		Min. 8. Data c (Monti	n. Dav. Yaari	9. Birthplace (Stata or Foral Country) Washington, DO
pura Manual	10a. State 10b. County	10c.	City, Town or	Location				10d. Insida City Limi
vith the Maryl to r 28a-f sho be notified a	MD Montgo	omery	Takoma					1 □ Yas 2 ☒ N
th with the 23s or 2	7404 Birch Avenue	2		10f. Zip Code 20912			10g. Citizen of US	
s. 1 and 2 should be filed within 72 hours after death with the Manyland of Health and Mentel Hygiene. If Health and Mentel Hygiene. Other traumatic event, the Medical Examinations to notified at other traumatic event, the Medical Examinations.  To Be Completed by Funeral Director	11. Maritel Status 1 □ Navar Married 2 ☐ Married 3 □ Widowed 4 □ Divorced	12. Was Decedant Evar in Armed Forcas?  1 □ Yas 2 □ No If Yas, Giva 194 Yaar or Detas:	44-46	3. Was Decedent of If Yes, specify Control of the Image		Igin? (Specity Yas on, Puerto Rican, atc	or No- 14. Rac Bla  Specify	ca - Amarican Indian, ck, Whita, atc. y: White
hould be filed within 72 hours Mantal Higgen. merked other than "natural", metic event, the Medical Exa To Be Completed by	15. Decedent's (Specify only highast g	rada completad)	16a. Dec (Gir lifa	cedent's Usual Occ va kind of work dor DO NOT use reti	upation na during mos red)	at of working		orcement/
there on	Elementary/Secondary (0-12)	Collega (1-4or 5+)		ce Offic			Plumbin	
Hygin Hygin	17. Fathar's Nama (First, Middla, Las	t)			18. Moth	ar's Nama (First, Mi	ddia, Maiden Sumar	na)
build be filed with Mental Hygiene arked other than atic event, treating To Be Comp	Cormac Anthony Re	pers			7404 E	Clizabeth	Curtin ko	ma Pk, MD 209.
and Men is marke aumatic	19a. Informant's Nama/Ralationship		19b. Ma	iling Addrass (Stre			umbar, Cify or Town	
and 2 : ealth ar n 27 Is er trau	Jeanne S. Rogers	s/Wife	7404	Birch A	ve. T	akoma Par	k, MD 209	12
Pages 1 and hent of Health nt: If hem 27 iry or other tr	20a. Mathod of Disposition  1 28 Burial 2 Cramation 3  4 Donation 5 Other (Spec	□Removal from State	b. Place of Dis camatary, cr	position (Name of ramatory or other p	vace)	Data	20c. Location	- City or Town, Stata Spring, MD
permit. Pages Department of Important: If it any injury or o	21. Signature of Juneral Service Lig	m 9 Ann					J. Collir Blvd., W	ns Funeral Vest
Physician /Medical Examiner Examiner Examiner	Immediete Causa (Finel disaase or condition rasulting in death)	Anteniosasy Due to	COTIC C		CUAR	Dispase		Onsat and Death
ing physician and as as the burial-transit	Sequantially list conditions, if eny, leading to immediata causa. Entar Undarlying Causa (Diseasa or Infury that initiated avants resulting in daeth) Lest	C	o (or as e cons					
signed by the attend d be datached for us.	Part tt. Other significant conditions	contributing to death but not	resulting In the	underlying ceuse	given In Part	I. 23b.	Did tobacco use co	ontributs to the cause of dear
as that the igned by be datac							1 □ Yss 2 No	3 Probably 4 Unknown
aw requisite the second							Was en autopsy performad?	24b. Wara autopsy finding available prior to complation of cause of death?
ata ha paga						1	1□ Yas 2 NO	1 □ Yas 2 No
certificata rector, pag	25. Was case rafarred to medical examinar?				26. Plac	e of Death (Check	only one)	
Physician: this certific ral director, To Be (	1 Nas 2 No	Hospital:	ER/Outpat	ient 3D DOA	Othar: 4 N	ursing Homa 5	Rasidanca 8 Dot	har (Specify)
	27. Manner of Death  1							rred
To the Hospital or Attending P within 24 hours sher death to To the Funeral Director. After toompletaly filled in by the funeral Medical Certification:	3 Suicida 6 Could not 4 Homicide datarmine		at homa, farm, ecify)	straat, factory, offic	ca		ion (Straat and Num or Town, Stata)	ber or Rural Routa Number,
To the Hospita within 24 hours To the Funeral completaly filled	29a. Cartifiar 1 Certifying F	thysician: To the best of my miner: On the basis of exam and mannar stated.	knowledge, de Ination and/or	ath occurred at the Invastigation, in m	tima, data ai y opinion, dai	nd place, and dua to ath occurrad at the t	tha causa(s) and m tima, data and placa,	annar as stated. , and dua to the causa(s)
1 < + \ N	29b. Signatura and titla of certifiar	n.O. (OMF)			5136			ed (Month, Day, Year)
	30. Nama and address of person who CARL I. MARGO	complated cause of death (		e, Print)	itro (	Pockvius	, MO 10	852
State Registrar	31. Data filad (Month, Day, Year) 1	32. Redistrar's Si	gnatura	· Ana	1/21		- 1	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** Jack Terry Rowland March 3, 1999 3:27 PM /Medical 4e Facility Name (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 6. Sex 1 → M 2 ☐ F 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours Yrs. 217-34-2136 Director 61 Maryland Usuei Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yes 2 No Director 28a-f Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itserns 23s or must be 8409 16th St, #114 20910 Funerai USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien. Black, White, etc. r than "natural", or Itse the Medical Examiner 72 hours after 1 ☐ Yes 2 ☑ No 1 ☐ Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within Elementary/Secondery (0-12) College (1-4or 5+) 6 Baker Bakery 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) permit. Pages 1 and 2 should be fill.
Department of Health and Mental Hy
important: If item 27 is marked oth
any injury or other traumatic even Be Richard D. Rowland Maxine Schildtknecht 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mary E. Rowland/Wife 8409 16th St, #114, Silver Spring, MD 20910 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete W Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery Mar 4 Brentwood, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signefure of Funeral Service Licensee Wormell alan 11800 New Hampshire Ave, Silver Spring, MD 20904 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Small Cell Lung Comcer /Medical Immediate Cause (Finei disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last and Due to (or es a consequenca of) Box 68760. Physician/Medicai Due to (or as e consequence of): 88 980 igned by the atter Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown by Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed has page 2 2 No certificate 1 Yes 1 Tyes or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitei: Inpatient 1 ☐ Yes 2 ☐ No 27. Menner of Deeth Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this funeral 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Neturel 2 Accident 5 Pending investigation 24 hours after death.

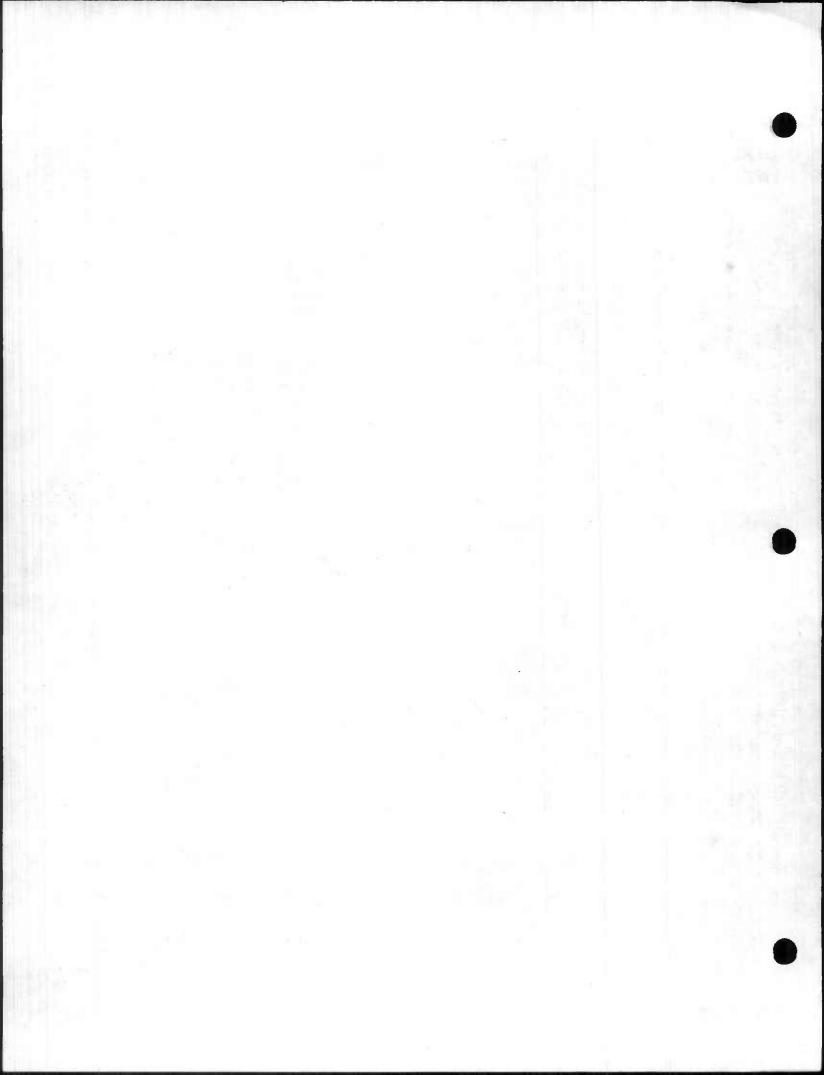
Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end manner as steted. completely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner stated. within 2 \$ 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 2 0 RVING STREET # 218, washington 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)\_ MATHUR 106 RAJ 32. Registrer's Signeture

**DHMH 16 Rev 6/95** 

State

Registrar

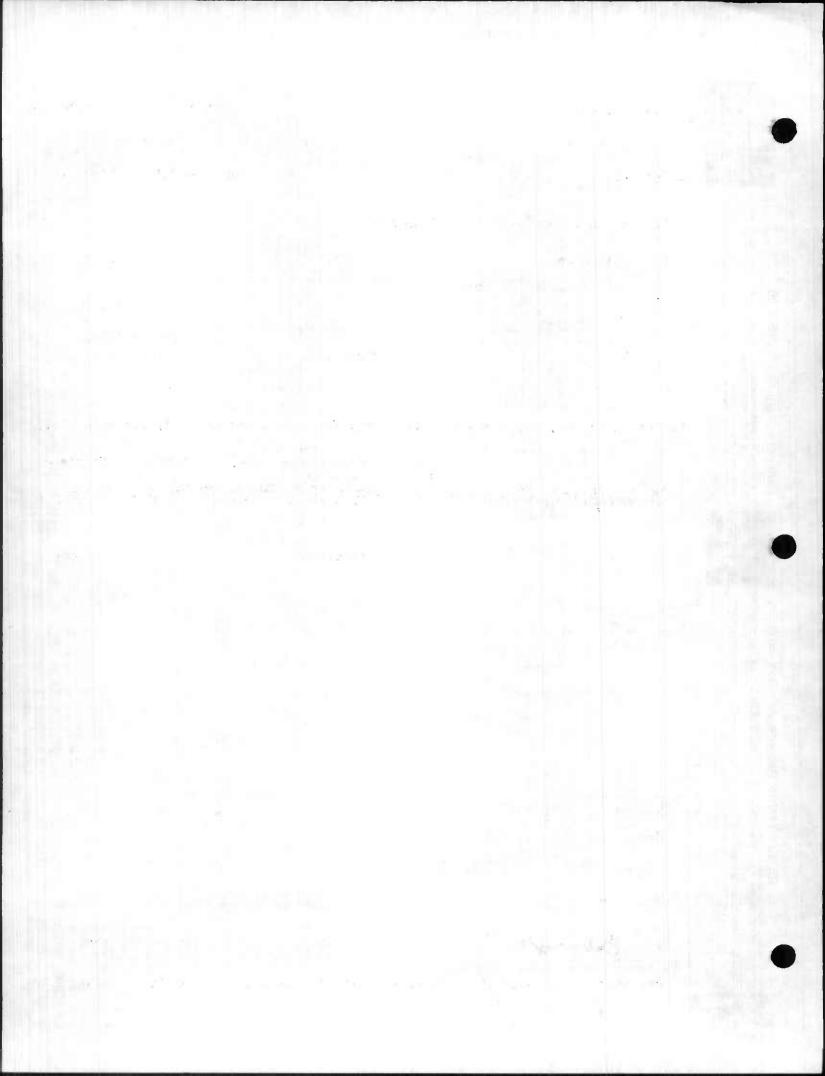
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State of Maryland / Department of Health and Mental Hygiene 0 0 0 0 0 0

						Cert	ificate of	Death		Reg. No.	9 0	3288
		1. Decedent's Neme	(First, Middle, La	st)	9.00	0=1			2. Dete of De	eth	V	3. Time of Death
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/Medic Examin	_	4e Facility Neme (If		e street end nu	mber)			4b. City, Town, or I			nty of Deeth	
LAdillin	S	4607 Map	le Avenue	0				Bethesd	la	Mon	tgome	rv
Funeral		5. Sociel Security Nu			7. Age (In yrs. I	est birthday)	If Under 1 Year	If Under 24 Hrs.				place (State or Foreign untry)
Director		578-24-410 Usuel Residence of	07	□M 2 <b>X</b> ) F	88	Yrs.	Months Deys	Hours Min.	August 2	26, 1910	V:	irginia
and and		10e. Stete	10b. County		10c. City	, Town or Loca	ation					10d. Inside City Limits
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5-0020 72 hours efter death with the Meryland naturel; or Heme 23e or 28s-1 show deat Examinet must be notified at	X F	10e. Street and Num		mcry		beenesa	10f. Zip Code			10g. Citizen o	of Whet Cou	untry?
with with		/(07 Non	1				2081	/.		IIn i +	ed Sta	2+00
in Seath	Funerai	4607 Map.	ie Avenu	12. Was Dec	edent Ever in U,	S. 13. W		Hispenic Origin? (S sen, Mexican, Puert	pecify Yes or No			ican Indien,
ftar d	5	1 ☐ Never Merrie	ed 2 Married	Armed Fo	orces?				o Rican, etc.)	В	leck, White	, etc.
Urs aff	þ	3 XWidowed	4 ☐ Divorced	If Yes, Gi Year or D	ve Dates:	1[	☐Yes 2[X]No	Specify:		Spe	oify: Wh	ite
72 hours	8		15. Decedent's Ed	ducetion		16a. Decede	nt's Usuel Occu	pation		16b. Kind of		
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O EISE	Bec	17. Father's Neme (I	First, Middle, Last,	)				18. Mother's Ner	me (First, Middle	, Meideri Sum	eme)	
should be and Mental marked o	ToB	Charles	Thomas :	Baines				Currie	Jane W	icker		
lore, Maryla ges 1 and 2 should to f Health end Men if item 27 is marke or other treumetic	-	19e. Informent's Na				19b. Malling	Address (Stree	t end Number or Ru			vn, Stete, Z	ip Code)
Ma 2 and 2 and 2 strike or traver		LGordon	Raines	Tr /	nenhew	6621	Grev Fo	x Drive,	Springf	ield.	Viroi	nia 22152
re, N 1 and 3 Health Hem 27 other tr		20e. Method of Disp		01.		-4 Di	· /A! 4			20c. Locatio	-	
			Cremetion 3 ☐ 5 ☐ Other (Specif					March 11		Potho	ada 1	Manual and
Baltimore, Normalist Pages 1 and Department of Health Important: If them 27 any Injury or other tonce.	1	21. Signeture of Fun			0 M0083		y Crema Name end Addr	torium, I	nc.	bethe	sua, I	Maryland
Baltii permit. F Departme Importan any Injur		Darbon	Marrales	ullen	Lawrer	Rol	bert A. P		eral Home Bethesda	/Betheso	la-Chev	y Chase, Inc. 314-3501
100		23a. Pert1. Enter the shock, or hear	e diseese, or com	plicetions that	ceused the deeth	. Do not enter	the mode of dy	ing, such es cardia	or respiretory e	errest,	1	Approximete Intervel Between
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/Medical		Immediate Cause (F	Finel		Myoca	rdial	Infarct:	ion				1 day
Examiner		resulting in death)		θ		r es e consequ						1 44)
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outed rensi	Examiner	Sequentially list con	ditions	b	Due to (or	r es a consequ	ence of):					
O, exe an ar irial-t	ŭ	Sequentially list con if eny, leeding to im- ceuse. Enter Under Ceuse (Disease or li	mediate tylng								i	
68760, ficata be executed physician and ts the burial-trensit	edicai	thet initiated avants		C	Due to (or	es e conseque	ence of):					
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death cert death cert e ettendin	Physician/M	Pert II. Other signific	cant conditions of		eath but not resu	ulting In the unc	tertving ceuse g	iven in Pert I	23b. Did	tobacco usa	contribute	to the cause of deeth?
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Records, P.O he law requires thet the e has been signed by th sge 2 should be detache	졌									s en eutopsy	24b. \	Were eutopsy findings
v requir	et								pen	ormed?		completion of cause of deeth?
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of Vita Physician: this certific ral director,	Be C	exeminer?		Hospitel:			•F 50. 0	hor	ath (Check only		Out (D	-26.3
Of Vital Physician: 7 This certificat ral director, p	2	27. Menner of Deeth			ALC: NO PERSON NAMED IN COLUMN TWO IS NOT THE OWNER.	ER/Outpetient 28b. Time of	3LI DOA	4 U Nursing F	dome 5 X Res			ягу)
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DIVISION for Attending efter death. Director: After d in by the fune	Certification:	4 Homicide	determined	build	e of Injury - At ho ing, etc. <i>(Specif</i> y	()	et, lactory, office			wn, Stete)		107110410744111001,
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n 24 h	edicai	(Check only one)	2☐ Medicai Exar	niner: On the b	esis of examinet ner steted.	ion end/or Inve	estigetion, in my	opinion, deeth occu	urred et the time,	, dete end ple	e, end due	to the ceuse(s)
Within To the comp	Σ	29b. Signeture end t	itle of certifier	2 . 0			29c. Licen	ise number		29d. Dete sig	ned (Monti	h, Dey, Year)
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Certificate of Death

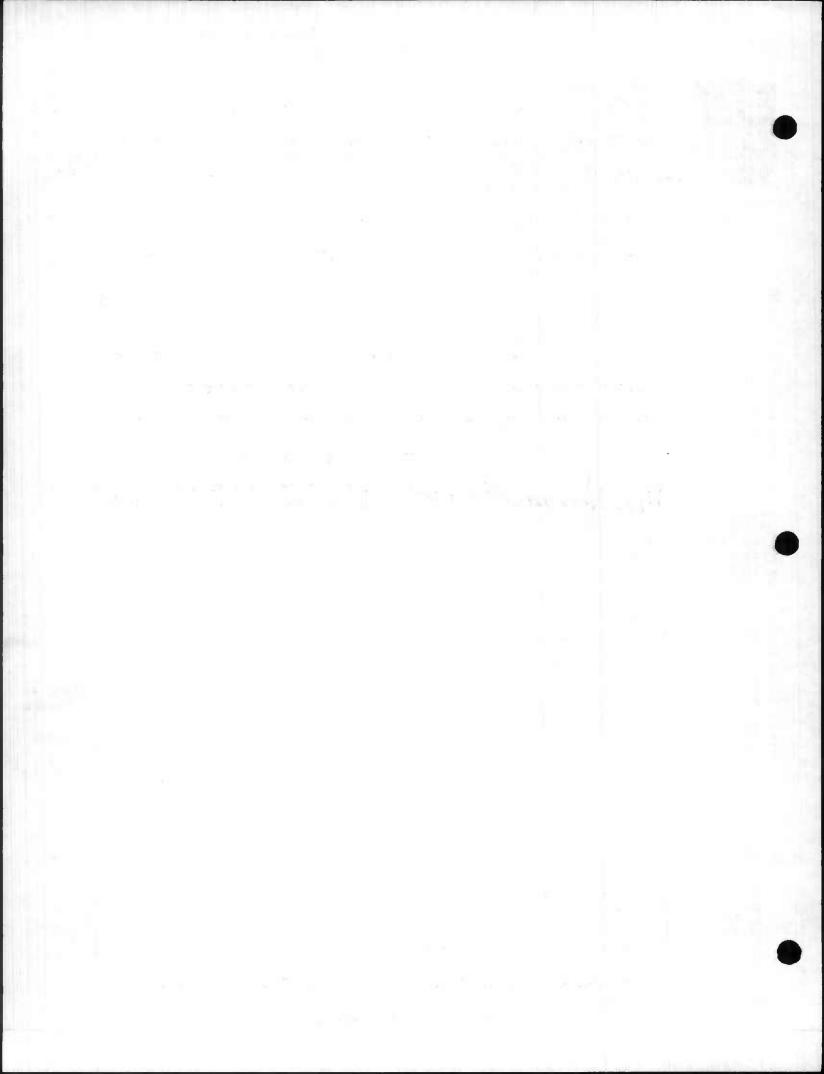
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Examin	er	4e. Facility Neme (If not institute Suburban Hos			umber)				4b. City, Too Bethe				Mont	ity of Death		
Funerai Director		5. Social Security Number 215–38–3125	6. 9	Sex ISLM 2□F	7. Age (In 80	yrs. last birthde Yrs.	y) If Un Mont	der 1 Yee hs Deys		24 Hrs. Min.	8. Det (Mc Dec	te of Birth onth, Day 28	Year) 1918	9. Birth Cou Nor	plece (S ntry) th	Stete or Foreign Carolin
a-f show	tor	Usuel Residence of Deceder  10a. Stete 10b. Co  MD Mon		ery		City, Town or Bethesd										side City Limits Yes 2図No
or 28	re	10e. Street end Number 10f. Zip Code							10g. Citizen of Whet					ntry?		
238	aiD	10116 Parkwoo	d Dr	ive 20814									US	SA	A	
5 2	by Funeral Director	11. Maritel Stetus 1 □ Never Married 2 ☒ 3 □ Widowed 4 □ Divo		12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No WWII If Yes, Give Yeer or Detes:				Vas Decedent of Hispanic Origin? (Specify Yes of Yes, specify Cuben, Mexican, Puerto Rican, etc  ☐ Yes 2 ☑ No Specify:				(es or No- l, etc.) 14. Race · Ar Bleck, Wi Specify:			mericen Indien, hite, etc. White	
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n and Mental Hygier Is marked other the reumatic event, the	Be	17. Fether's Neme (First, Mid Robert S. Rus		)		Engi	neer		18. Mothe		ne (First, Barr	Middla, I				
d Me mark	2	19e. Informent's Name/Relet		Time (Print)		10h 14a	ilio - A dala	ana (Ctra	-				Ch. as Tou	- Ctata 7	- 0-4-1	
Department of Health and Important: if item 27 is meny injury or other treum 2009.		Sudie B. Russ 20a. Method of Disposition			20	1011	6 Pa	rkwoc	od Dr.,			sda,	MD 208	314		
tment of tant: if its ijury or o		1 Burial 2 Cremat 4 Donetion 5 Othe	r (Specif	y)	State	etropol	Plece of Disposition (Nema of cametery, cremetory or other plece)  cropolitan Crematory				Deta 20c. Location - City or Town, St 3/11/99 Alexandria, VA			ate		
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Medical multiple with the properties of the prop	Physician/Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth)  Sequentielly list conditions, if eny, leeding to immediate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest	{	a. Atl b. Hy c. Hy	Due Due	to (or es e consumeros) to (or es e consumeros) to (or es e consumeros)	equence equence	of): of):	- De	seci	se				15.	jr ·yı
the etter	iclar	Pert II. Other significant con	ditions o	ontributing to d	leath hut not	resulting in the	underlyin	o cellee o	iven in Part I		25	3h Did to	hacco use o	ontribute t	o the c	ause of death
peen signed by the ette should be deteched for	by Phys	multi uf						9 00000 9				23b. Did tobacco use contribu			□ Probably 4 Unknow	
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ped												1 □ Y	os 2 No	1	Yes	2□ No
is certificete director, per	Be	25. Was case referred to me examiner?	lical	Hospital:					26. Plece	of Deal	th (Chec	k only on	a)			
this did	ation: To	1 Yas 2 Accident	nding estigation	28e. Date (Mon	28e. Date of Injury (Month, Dey Year)  2 ER/Outpatient 2 ER/Outpatient 3 DOOA Ott Wo M 1 1				4 🗆 190	rsing Home 5 Residence 8 Other (Specify)  28d. Describe how Injury occurred						
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within 24 hours after To the Funeral Dire completely filled in b	edicai	29a. Certifier 1 Cert 2 Med	fying Ph cai Exam	niner: On the b	best of my basis of exam ner steted.	knowiadga, daa ninetion end/or l	ith occurr Investiget	ed et the t ion, in my	ime, dete end opinion, deet	d place, th occur	and dua	a to tha co a time, d	ausa(s) and r ate end place	nanner es s e, and due t	stated. to the ce	ouse(s)
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H		30. Name and addrass of per		complated cause	sa of death (	(Item 23e) (Type	e, Print)	0 3	2610				3-10-9	9		-
Sta	Α.	TJM NAMES 31. Dete filed (Month, Dey, Y	121	mo.	5602 Registrer's S	Shields		e Pe	thes de	4	Ma	2	0817			



State of Maryland / Department of Health and Mental Hygiene

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Ì	Examir		4e. Fecility Neme (If not institution, give						r Location of Deet	h 4c. County	of Deeth			
			SHORE NURSING					DENTO			LINE			
	Funeral Director		5. Sociel Security Number 6. S 298-14-4173  Usuei Residence of Decedent	ex	e (In yrs. las 4	t birthday) Yrs.	If Under 1 Yes Months Dey			th xy, Year) 2, 1904	9. Birthpli Count NEE	ace (State lry) BRASK	or Foreign A	
	show	5	10a. State 10b. County 10c. City, Town or Location									10d. inside City Lim		
	the N	Director	MD 10e. Street end Number	TALBOT			EASTON 10f. Zip Code						, 263110	
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020	urs o	by Funeral	11. Maritel Status  1 ☐ Never Merried 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Wes Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Yeer or Detes:				Hispenic Origin? (Specify Yes or N ban, Mexican, Puerto Rican, etc.)		o- 14. Race - Am Black, Whi				
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ylar	D P P P	To B	FRANKLIN LEROY	TRAVER, S	CAVER, SR. BESSIE					HENDERSON				
Maryland			19a. Informent's Name/Reletionship ( ELIZABETH R. DIXO				_	et and Number or F				Code)		
Baltimore,	of Her		20e. Method of Disposition  1  ☐ Buriel 2 ☐ Cremetion 3 ☐  4 ☐ Donetion 5 ☐ Other (Specification of the control of the contro	Removal from State	20b. Pled	e of Dispos etery, crem	sition (Name of natory or other p	(ace)	Date 3-12-99	20c. Location -	City or Tov	wn, Stete		
Balti	permit. Page Depertment of Important: If any Injury or once.		21. Signeture of Funeral Service Licen	·	CFS	Ø FI	. Name and Add		IN & NEW	NAM FUNE	RAL H	IOME,	P.A.	
	Physician /Medical Examiner	ner	23a. Pert1. En er the disease, or com shock, or heert feilure. List only Immediate Ceuse (Finei disease or condition resulting in death)	a. Two to u	10.	À					i	Approxima interval Be Onset end	blween Deeth	
oʻ	tificete be executed g physician and es the buriel-transit	Examiner	Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or injury that Initiated events	b	Due to (or a	s a conseq	uence of):				1			
Box 68760,		Physician/Medical	Cause (Disease of Injury that Initiated events resulting In deeth) Last	-										
ď	the death cery y the attendir sched for use	cia	Part II. Other significant conditions of	entribution to death by	it and somethic	na la tha u	dodules esuas	nium in Dant I	OSP DIA	23b. Did tobacco use contributa			n to the cause of death?	
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0	nding P ath. r: After t	ation:	27. Menner of Deeth  1 XNeturel 5 ☐ Pending 2 ☐ Accident investigation	28e. Dete of Injur (Month, Day	Year) 28	3b. Time of Injury	28c. in W M 1	juryet fork? □Yes 2 □No	28d. Describe	how injury occur	red			
DIVISION	To the Hospital or Attending Ph within 24 hours elect death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Sulcide 6 Could not be 4 Homicide determined	0	28f. Location ( City or To	Street and Numb wn, State)	er or Rural	Route Nur	nber,					
	e Hosp 24 hot Funer letely fil	edical	29a. Certifier 1	raician: To the best of iner: On the basis of and manner sta	examinetion	dge, deeth end/or inv	occurred at the estigation, in my	time, date end pled opinion, deeth occ	ce, end due to the curred et the time,	cause(s) end ma dete end plece,	inner as ste end due to	eted. the cause(	s)	
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)			Main			_	1,0	0294		3/10/9	9			
			ERIC HERMANS					VE, CHES	TER, MD	21619				
	Sta	te	31 Dale filed (Month Bay Wood)	1999 32. Registr			4 1							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month Day **Physician** Beatrice Louise RODGERS 2, MARCH 1999 5:55pm /Medical 4b, City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street and number) **Examiner** William Hill MAnor EaSTON Talbot 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdey) 8. Dete of Birth (Month, Dev. Year) **Funeral** Hours 10 M 2 F Months Devs Yrs. 081-07-1279 93 Director Jan. 6,1906 New York Usual Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Yes 2 No Directo Talbot Easton 10e. Sireet and Number 10f. Zip Code 10g. Citizen of Whet Country? with r than "natural", or flems 23s or the Medical Examiner must be 21601 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Heath and Mental Hyglena.
Int: If term 27 is marked outher than "natural", or florme 23.
Int or other traumatic event, the Marcal Emirine must my or other traumatic event, the Marcal Emiries must Funeral 501 Dutchmans Lane 14. Rece - American Indien, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2000 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Married White Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: þ 3€ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker OwnHome 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Feiher's Name (First, Middle, Last) J. Warren Archer Louise Packard 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Ian Todhunter /Son 14 Carriage Road, Cos Cob, CT 06807 20b. Place of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, Stete Chesapeake Cremation 1 Buriai 200 remetion 3 Removel from State permit. Page Department of Important: If any Injury or once. 3/5/99 4 ☐ Donetion 5 ☐ Other (Specify) Chester Center LLC Funeral Service License 22. Name end Address of Fecility Funeral Home, 200 South Harrison Street Easton, MD 21-601 It enter the mode of dying, such as cardiac or respiretory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximete Intervai Between Onset and Death **Physician** /Medical Immediate Cause (Final MEHU CARDIA VENTRIC SUM INDIDINTE diseese or condition resulting in deeth) Examiner Examiner INFLUENZA that the death certificate be axecuted physician and s the burial-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting In deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as e consequence of): 88 980 signed by the a 23b. Did tobscco use contribute to the cause of death? Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 2 No 3 Probably 4 Unknown p 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed CHRONIC ATRIAL FIBRILLATION 24a. Was en eutopsy page 2 s 212 Kg 1 Yes 1 ☐ Yes 2 ☐ No cartificata Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospitei: Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28d. Describe how injury occurred 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: After 1 Naturei Attending 5 Pending investigation death. 1 Yes 2 No 2 Accident aftar deati Director: the Funeral Director of the Fu 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 6 Hospital Sertifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) end manner as stated. 29e. Certifier Medicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c License number 29b. Signature and title of cartifier - Uw. Frain D00250

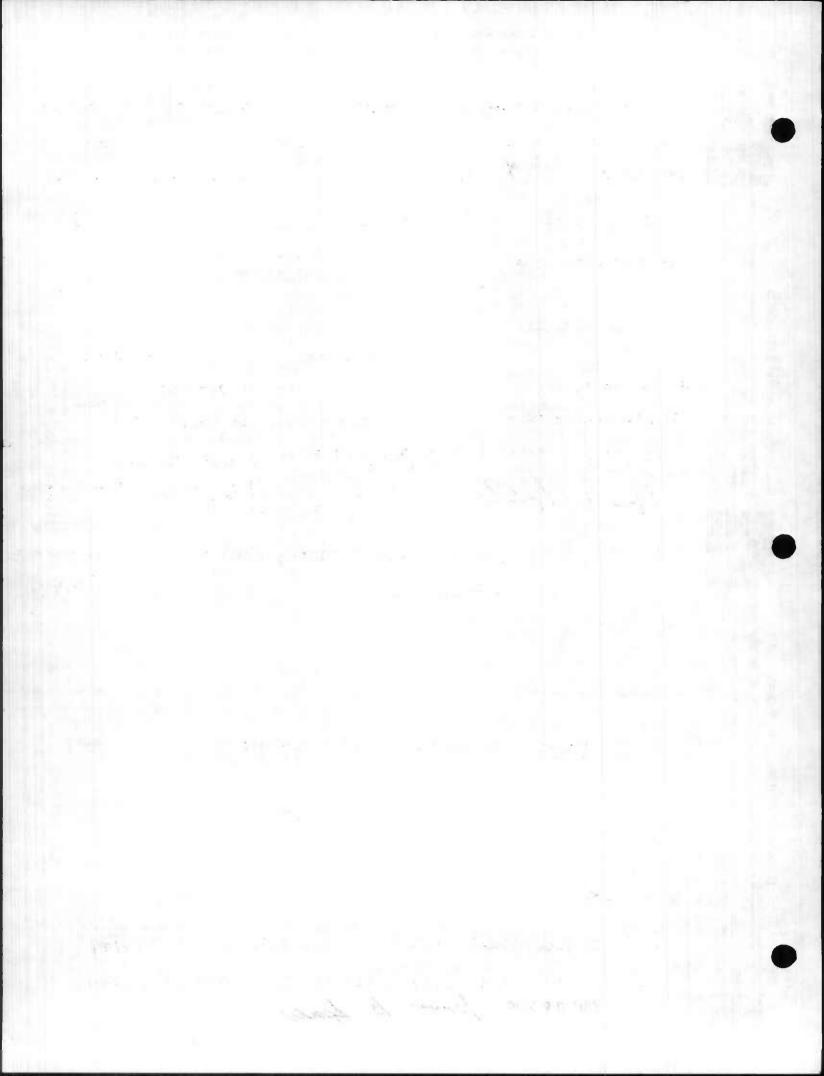
DUTCHTIM'S LANE,

EASTON, M.

State Registrar 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

609 0 8 199932. Registral's Signature

C.RW. BAN



### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Month Day Year **Physician** RICHARDSON ELTON 0613 1999 4b. City, Town, or Location of Deeth 4, /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner BERLIN If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 7 - 1 - 0 9 10428 FRIENDSHIP ROAD 5. Social Security Number 6. Sex, 7. WORCESTER Birthplace (Stete or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** 75 M 20 F Days Months MD Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or itams 23s or 28a-1 show any injury or other traumatic event, the Medical Events. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No BERLIN Directo MD. WORCESTER 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 10428 FRIENDSHIP ROAD 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₹2 No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 □ Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) PAINTER CONSTRUCTION 12 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maidan Sumame) MARGARET ANN RODGERS CHARLES HENRY RICHARDSON 19b. Mailing Addrass (Straet end Number or Rurel Route Number, City or Town, Stata, Zip Code) 19a. informant's Name/Raletionship (Type, Print) Mp., 21811 10428 FRIENDSHIP RD. BER; IN, JENNIE K. RICHARDSON / SPOUSE 20b. Placa of Disposition (Nema of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State SUNSET MEMORIAL PARK BERLIN, MD. 22 Name and Address of Fecility ULLRICH FUNERAL HOME BERLIN, MD. ther the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, or haart failura. List only one cause on each line. Approximata Intarval Batwaan Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the burief-transit thet the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or es e consequence of) 98 usa signed by the sid be detected for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Records. P 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy Completed paga 2 s 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yas cartificeta Division of Vital or Attending Physician: 25. Was casa rafarred to modical examiner? director, Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Aftar this funaral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 [] Natural 5 Pending investigation after deeth. 1 Yes 2 No 2 [] Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 24 hours after de Funeral Diracto lataly filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Hornicide Hospital 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Wedical within 24 hor To the Fune complately fi (Check only one) \$ 29d. Date signed (Morth, Dey, Year) 29c. License number 29b. Signature and title of cartifier 2

on who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

D34976

Salisbum, no

Harold I Genvert MI

State Registrar 30. Name and address of per

31. Data filed (Month, Day, Year)

IAR 0 5 1999

Marine the contract of the con

# Christopher Ruark SS#217.949085 Baltimore, Maryland 21215-0020

Box 68760,

P.O.

Records,

of Vital

Division

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month Day Veer 9,1999 2008 Christopher Dean Ruark Mouth /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SALISBURY WICOMICO PENNINSULA REGIONAL MEDICAL CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | 3. Detection | 4. Detection | 5. D 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) Funeral 1**X** M 2□ F Yrs. 217-94-9095 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits Md. Wicomico Salisbury 1 XYas 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? нетв 23а US 21802 Rt. 12 Snow Hill Road 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, atc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married "natural", or White 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 7 and Mental Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) None None Tis mert 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Frank D. Ruark Teresa Hastings 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Health mportant: If Item 27 10204 Hayes Landing Rd., Berlin, Md. 21811 Frank D. Ruark 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other placa) 20c. Location - City or Town, Stete to Burial 2 Cramation 3 Ramoval from State 4 Donetion 5 ☐ Other (Specify) 3-12-99 Libertytown, Md. Riverside Cemetery Service Licensee 22. Name end Address of Fecility The Burbage Funeral Home In disease, or complications the ceused tha death. Do not enter the mode of dying, such as cerdiac or respiretory errest, in feilure. List only one ceuse on each line. Approximete Interval Between Onsat and Deeth Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) preumonin 3 days Examiner Due to (or es a consequence of): Rhabdo myo ly 80 3 days that the death certificete be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting In deeth) Lest and Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Remodation þ 24b. Were eutopsy findings evelleble prior to completion of causa of deeth? Be Completed 24a. Wes en eutopsy performed? Placement pege 2 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 24 hours effer death. Funeral Director: After this certifica stely filled in by the funeral director, § 25. Wes cese referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 Nnpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours of To the Funeral Completely filled 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end manner es steted.

2 Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29e. Certifier Medical (Check only 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 047094 Natsahi 3/10/99 30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print) suite sux B salisbury MD 21804 ANATESAN, MI) 106 MILFORD ST. 31. Dete filad (Month, Dey, Year) 32. Registrer's Signeture State MAR I 1 1999 doorker Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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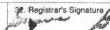
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH ALICE F. RICHMOND 1999 12:10 AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CUMBERLAND NURSING HOME CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Yeer)

DEC 11,1913 PENNSYLVANIA 5. Social Security Number If Undar 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Days 235-22-5186 85 Yrs Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location r than "naturel", or itams 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits MARYLAND ALLEGANY CUMBERLAND 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 223 GLEN STREET 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ﷺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p Specify: WHITE 3 Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filed will Department of Health and Mental Hygien, important: if Item 27 is marked other that any injury or other trainment. OWN HOME HOUSEWIFE 12 17 Father's Name (First Middle Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) PHILLIP McCARTHY JOSEPHINE PERSTON 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 223 GLEN STREET, CUMBERLAND, MD 21502 JOHN C. RICHMOND, JR./SON 20a. Method of Disposition 20b. Piaca of Disposition (Name of cemetery, cremetory or other place) MARCH 8, Date 1999 30c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State LAFAYETTE MEMORIAL PARK BRIER HILL, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Sepature of Funeral Service Licensee 22. Name and Address of Facility
HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HY, LAVALE, MD 21502 23a. Part1. Enter the drawse, or complications that caused the daath. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heert fellow. List only one ceuse on each line. Approximate erval Beh Onsat and Daath Physician docus. this ules 7Medical Immediate Causa (Final diseasa or condition rasulting in death) 4000 **Examiner** Examiner The law requires that the death certificate be executed and Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the bunal-P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ cate has been sig 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performad? 1 Yas 2 No Vital certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p Be 25. Was case referred to medical 28. Plece of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 27. Mannes of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide Medical 29a. Certifier Ceptifying Physician: To the best of my knowledge, death occurred et the time, date and pleca, end due to the cause(s) and menner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and menner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D36766 MACH 4,1998 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) VIK POONAI, 920 NATIONAL HWY, LAVALE, MD 21502

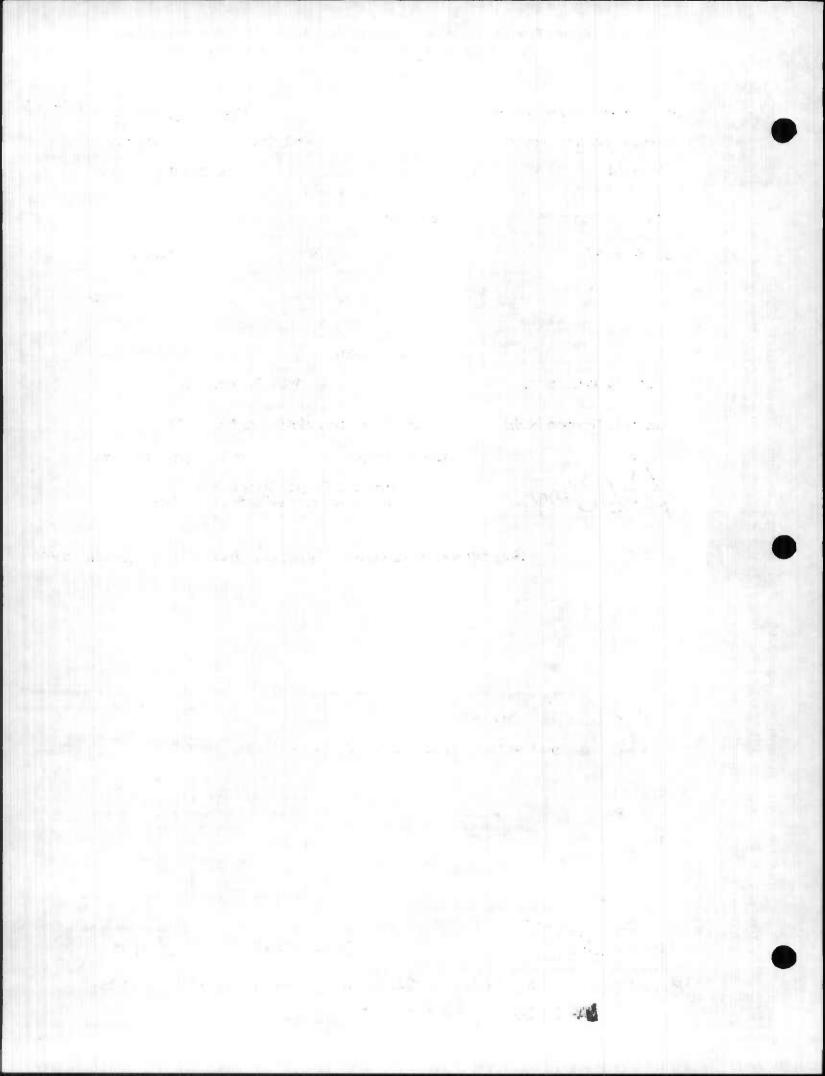
State Registrar 31. Date filed (Month, Dey, Year)

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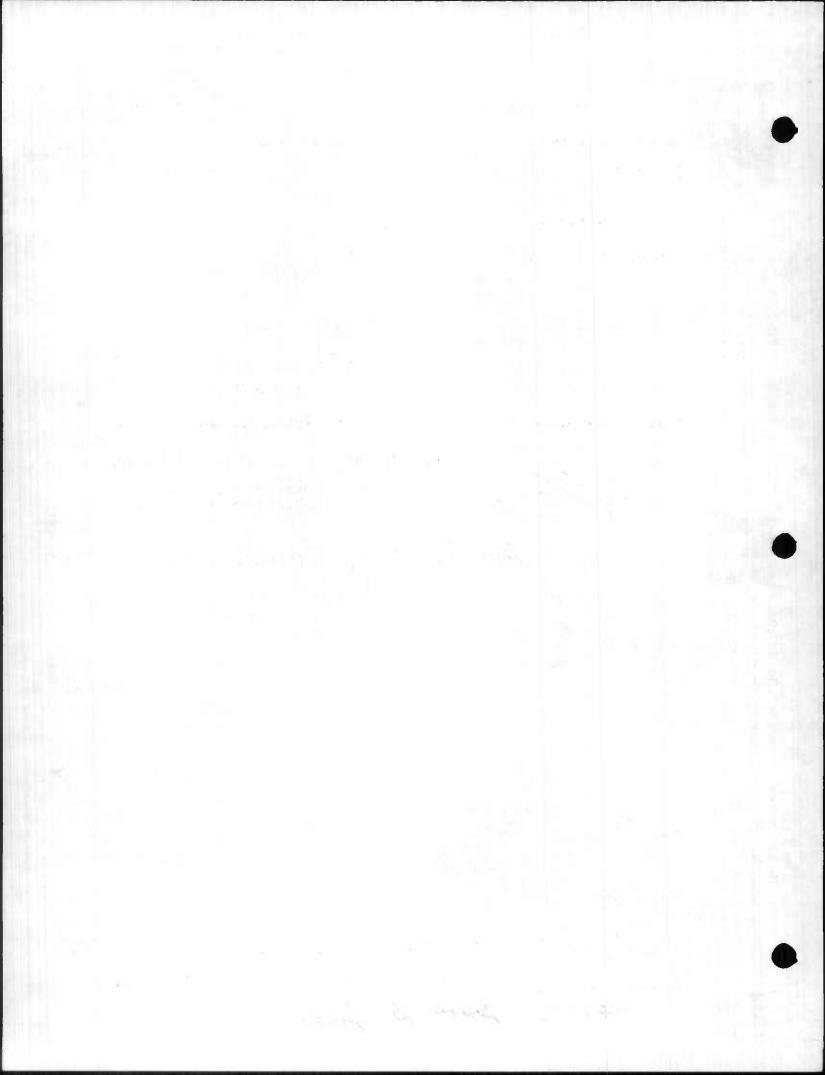
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Armed Force  1 Never Married 2 Married  3 Widowed 4 Divorced  Armed Force  1 9 8 3  If Yes, Give Yeer or Date				orces? 2 No			specify Cub	dispente Originan, Mexican,  Specify:	Puerto F	Rican, etc.)		14. Rece - American Indian, Black, White, etc.  Specify: White  Kind of Business/Industry				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Conservella T. Reynolds March 1999 6 354 /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner 506 Overbrook Drive Salisbury Wicomico If Under 1 Year If Under 24 Hrs.
Months Devs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Deys 1□M 2√2 F 218-20-9189 Yrs. 73 Director Nov 15, 1925 NC Usuel Residence of Decedent the Marylend r 28a-f show 10e State 10h. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 2 any injury or other traumatic avent, the Medical Examination and Dece. 506 Overbrook Drive 21801 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien 11. Marital Stetus Bleck, White, etc. 1 Never Married 2 X Married Specify: Black altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com, 16b. Kind of Business/Industry grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 5 Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be John I. Murphy Cloatie Cherry 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Bennie Reynolds/husband 506 Overbrook Drive, Salisbury, MD 21801 20b. Placa of Disposition (Neme of cametery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from State 4 Donation 5 Other (Specify) Springhill Memory Gardens 3/12/99 Salisbury, MD 21. Signature of Juneral Service Licegaeti 22. Name end Address of Fecility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Coven Immediate Ceuse (Final disease or condition resulting In deeth) /Medical **Examiner** Due to (or as a consequence of Examiner The law requires that the death certificate be executed physicien and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequenca of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of) ettending pl signed by the e 23b. Did tobacco use contributs to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown g 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed s certificate hes t i or Attending Physician: after death. Director: After this certifica director. 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Assidence 8 Other (Specify) Certification: To No No 1 Inpetient 2 ER/Outpetient 3 DOA 1 Tyes funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation Naturel 1 ☐ Yes 2 🗆 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 5 4 Homicide in 24 hour. the Funeral Direction 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner as stated. Medical To the Hosp within 24 hou To the Fune completely fi (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end manner steted. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certif 29c. License number Name and address of person who completed cause of deeth (frem 23e) (Type, Print) 1456 10 quall 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature MAR 0 9 1999

**DHMH 16 Rev 6/95** 

Registrar



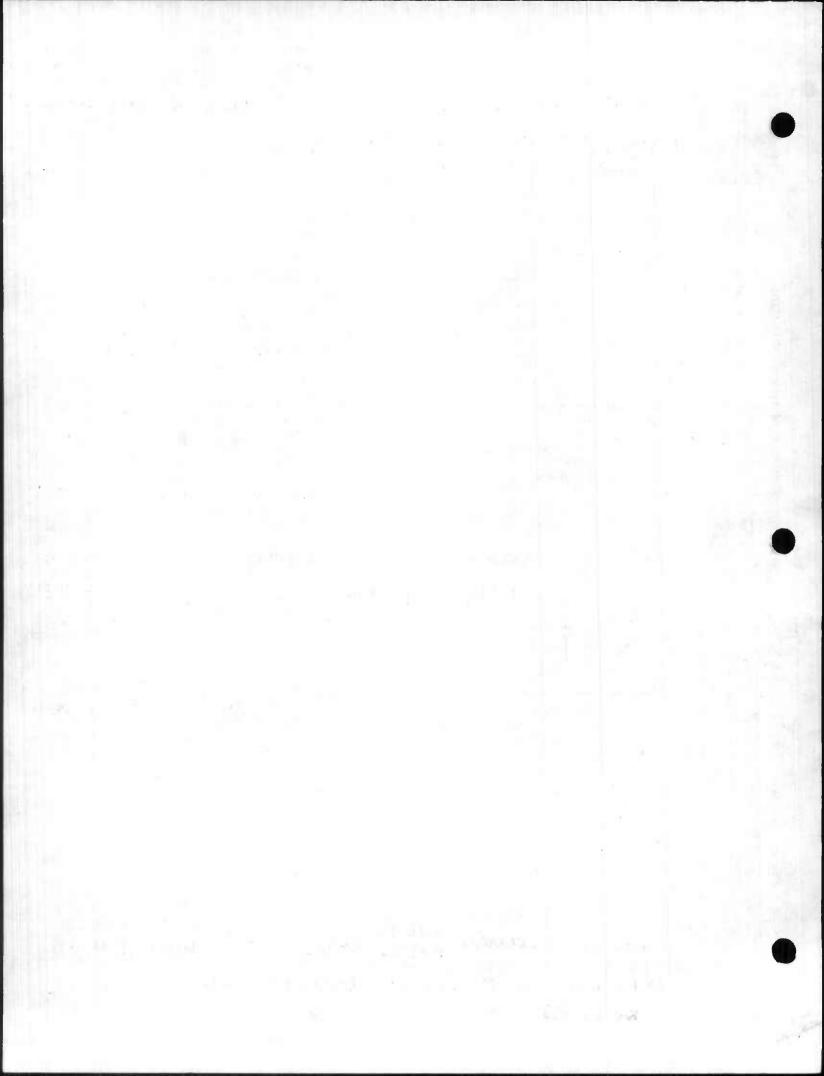
State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Day Month **Physician** RANDALL, JR. 5:40 a.w. VERNON MARCH 4 1999 /Medical 4e Facility Neme (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Deat **Examiner** UNIVERSITY of MARYLAND MEDICAL SYSTEM BALTMORE N/A If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 15M 20 F 228-36-2485 68 Director VIRGINIA Usual Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City. Town or Location 10d Inside City Limits 28a-f show 1 ☐ Yes 2 No GLEN BURNIE Director ANNE ARUNDEL MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21060 II.S.A. 1336 HOWARD ROAD Items 23s Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1950 – If Yes, Give 14. Race - American Indian, 11. Meritel Stetus Black, White, etc. should be filed within 72 hours effer on Mental Hygiene.

marked other than "natural", or itee 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify: þ 3 Widowed 4 Divorced 1973 Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. GOVERNMENT Elementery/Secondary (0-12) College (1-4or 5+) TECHNICIAN COMMUNICATIONS CIVIL SERVICE 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked othe any Injury or other treumatic event, 9068. 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) MAE WILLIAMS RANDALL, SR. LILLIE VERNON CLYDE 19a. Informent's Nema/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. DENISE GALLAGHER (FIANCEE) 3680 KENYON AVENUE, BALTIMORE, MD. 21213 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 3/8/99 XXBurial 2 ☐ Cremetion 3 ☐ Removel from Stete MARYLAND VETERANS CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) CROWNSVILLE, MD. 22. Name and Address of Fecility SINGLETON FUNERAL HOME, P.A., 21. Signeture of Europeu 3 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 ex e, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Intervat Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Sisperted poliumany hemorrhage 6 hours Examiner Examiner 3 mouther multiple mueloma The law requires that the death certificate be assecuted physician and s tha burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of Box 68760, Physician/Medical Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. been signed by the should be detach 3 Probably (Unknown 1 Yes 2 No Records, by 24b. Were autopsy findings available prior to Completed 24a. Wes an eutopsy performed? completion of cause of death? page 2 has 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Neturel 5 Pending investigation 1 | Yes 2 | No deeth. 2 Accident hours after deet neral Director; 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hou. 4 Homicide Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29a. Certifier (Check only one) Medical within 24 ho To the Fune completely f \$ 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number resident J.WAZARIAN RBYBS March 4, 1999 physician nd address of person who completed cause of death (Item 23a) (Type, Print) baltimore, Md 21201 M.D. J. WA ZARIAN 22 S. Greene St

State Registrar

31. Dete filed (Month, Dey, Year) MAR 0 8 1999 37 Registrer's Signeture



# 2055 BACH

**Physician** 

/Medical

Examiner

Registrar **DHMH 16 Rev 6/95** 

**Funeral** 

Director

2

1. Decedant's Nama (First, Middla, Last)

4e Fecility Nama (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

10b. County

(NMN)

1 □ M 2 🗓 F

ANNE ARUNDEL

ELIZABETH

5. Sociel Security Number

214-01-3817

MARYLAND

10e. Street and Number

10a. Stata

Usual Rasidance of Decedan

Directo ne 23a or 402 MILTON AVENUE 21060 U.S.A. Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarlo Rican, etc.) 14. Race - American Indian, 11. Maritel Stetus 12. Wes Decedant Ever In U.S. Armed Forcas?
1 ☐ Yas 2 No than "natural", or iten the Medical Examiner Black, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Giva Yaar or Dates: Specify: WHITE by 3 ₩idowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. MACHINIST AIRCRAFT 12 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Surname) 88 1 and 2 should be and Mental WILFORD DWYER MAMIE REHMERT 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Hoalth of Health 27 is ROBERT J. ROSSBACH (NEPHEW) 19 SEWARD AVENUE, BALTIMORE, MD. 21225 Baltimore, 20b. Plece of Disposition (Nama of cematary, cramatory or other plece) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Pages 8 Burial 2 Cramation 3 Ramoval from State important: It any injury or 4 ☐ Donation 5 ☐ Other (Specify) 3/9/99 BROOKLYN PARK, MD. HOLY CROSS CEMETERY 22. Nama and Addrass of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 complications that caused the daath. Do not enter the mode of dying, such as cerdiac or respiretory errest, Approximete Intervat Between Onset and Death **Physician** /Medical Immediata Cause (Final disaasa or condition resulting in death) Examiner Examiner physician and s the burial-transit death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaasa or injury thet Initiated avants rasulting in daath) Last Dua to (or as a consaquance of): P.O. Box 68760. Physician/Medical Due to (or as a consaquance of): 88 980 for ed by the a 23b. Did tobacco usa contributa to the causa of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by i 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Q 24b. Wara autopsy findings available prior to Completed 24e. Wes en eutopsy pariormed? completion of cause of death? page 2 has 1 Yes 1 TYas 2 No. certificate Physician: director 25. Was casa refarred to medicat axaminar? 26. Placa of Daeth (Check only ona) Be Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) P 1 Yas 2 No Inpatiant 2 ER/Outpatient 3 DOA this funeral 28e. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: After or Attending 1 Natural 2 Accidant 5 Panding s after death. 1 ☐ Yas 2 ☐ No invastigation 6 Could not be datamined 3 ☐ Suicida 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 6 4 Homicida filled in Hospital 24 hours 15 Cartifying Physician: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(s) and mannar as steted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifier edical To the Hosp within 24 hor To the Fune completely fi (Check only 29c. Licensa number 29d. Date signad (Month, Day, Year) 29b. Signatura and titla of certifier Name and account of person who complated cause of death (Item 23e) (Type, Print) Rume · wo. towe 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State MAR 0 8 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

If Under 1 Yaar

GLEN BURNIE

10f. Zip Coda

Months

Deys

ROSSBACH

7. Aga (In yrs. last birthday)

10c. City, Town or Location

82

Reg. No.

Day

4c. County of Death

10g. Citizan of What Country?

ANNE ARUNDEL

MARYLAND

2:40 Pm

Birthplace (Steta or Foraign Country)

10d. Insida City Limits

1 Yes 2 No

2. Data of Death March

8. Data of Birth (Month, Dey, Yeer)

01-17-1917

4b. City, Town, or Location of Death

GLEN BURNIE

If Under 24 Hrs.

Hours

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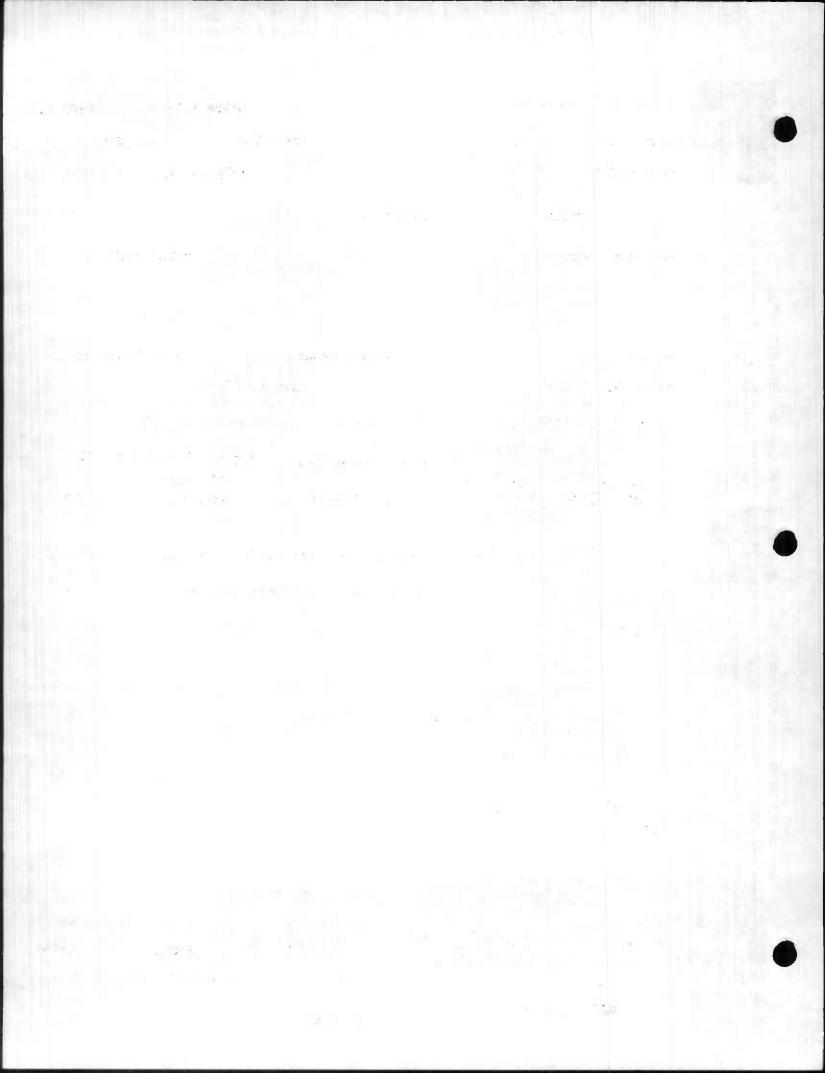
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State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Stanley Phillip Rebar MARCH 1,1999 5:00 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Allegany Sacred Heart Hospital Cumberland If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number Birthpiece (Stete or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** 113 M 2□ F Months Deys Hours 64 Yrs. 236-50-0632 Director July 16, 1934 Maryland Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours efter death with the Meryland neat of Health and Mental Hygiens.
ant: If item 27 is marked other than "natural", or items 23s or 28s-f show thy or other traumatic avent, the Medical Exempter must be notified at uny or other traumatic avent, the Medical Exempter must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a Stete 10b. County in and Menial Hygiena. 7 is marked other than "natural", or frems 23s or 28s-f show traumstic avent, the Medical Examiner must be notified at 1 Yes 2 No Md Garrett Bloomington Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 68 Knight Street 21523 United STates 14. Raca - American Indian, Black, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Yes 2 No 1 ☐ Never Merried 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) O'Sullivan Corp. Unknown Plastics Manufacture 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Frederick T. Rebar Mary E. Flynn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. informent's Name/Relationship (Type, Print) 213 Smoot St. Westernport, Diane Rebar / Wife MD 21562 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) parmit. Page Department of Important: If any Injury or page. Cumberland, MD 3/3/99 Cumberland Crematory 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility 111 Church St. Westernport, MD 21562 Boal Funeral Home 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel 5 days. diseese or condition resulting in death) ACUTE CONCESTIVE HEART FAILURE Examiner Due to (or es e consequence of): Examiner Due to (or exa consequence of): physician and the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Box 68760, Physician/Medical Due to (or as e consequence of): 89 usa signed by the aid P.O. Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the ceuse of death? 1 Probably 4 Unknown CIRRHOSIS OF LIVER; Division of Vital Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24a. Wes an eutopsy Completed page 2 hes 1 Yes 2 PNo 1 Yes 20 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No 2 this funeral 28e. Dete of injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: Hospital or Attending P
 24 hours after death.
 Funerel Director: After t After 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcide 24 hours aftar de Funerei Directo detely filled in by ti 28e. Plece of injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end pieca, and due to the cause(s) end menner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end pieca, end due to the cause(s) end menner stated. 29e. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month. Dev. Year) 29c. License number 29b. Signeture end title of certifier M.0 23334 - 7 MARCH 1999 PHILA 30. Neme and eddress of person who completed cause of deeth (item 23a) (Type, Print) MED BLDG, CUMBERLAND, MD 21502. JOHNSON 205 SHAK, M.D ; HTS 32. Registrer's Signeture 31. Dete filed (Month, Dey, Yeer) MAR - 2 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month **Physician** Lewis Lee Reichert February 26, 1999 11:59 PM /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Garrett County Memorial Hospital Oakland
If Under 24 Hrs.
Hours | Min. If Under 1 Year 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) Birthpiece (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Days 15M 20 F Monthe Yrs. 188-07-4514 **Director** Jan. 7, 1908 Virginia Usuet Residence of Decedent the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show show 1 ☐ Yes 2 ☐ No Director W/V Preston Kingwood 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? With 7 is marked other than "natural", or items 23s or traumstic event, the Medical Example must be permit. Pages 1 and 2 should be filed within 72 hours after death to Department of Heelth and Mental Hygiene.

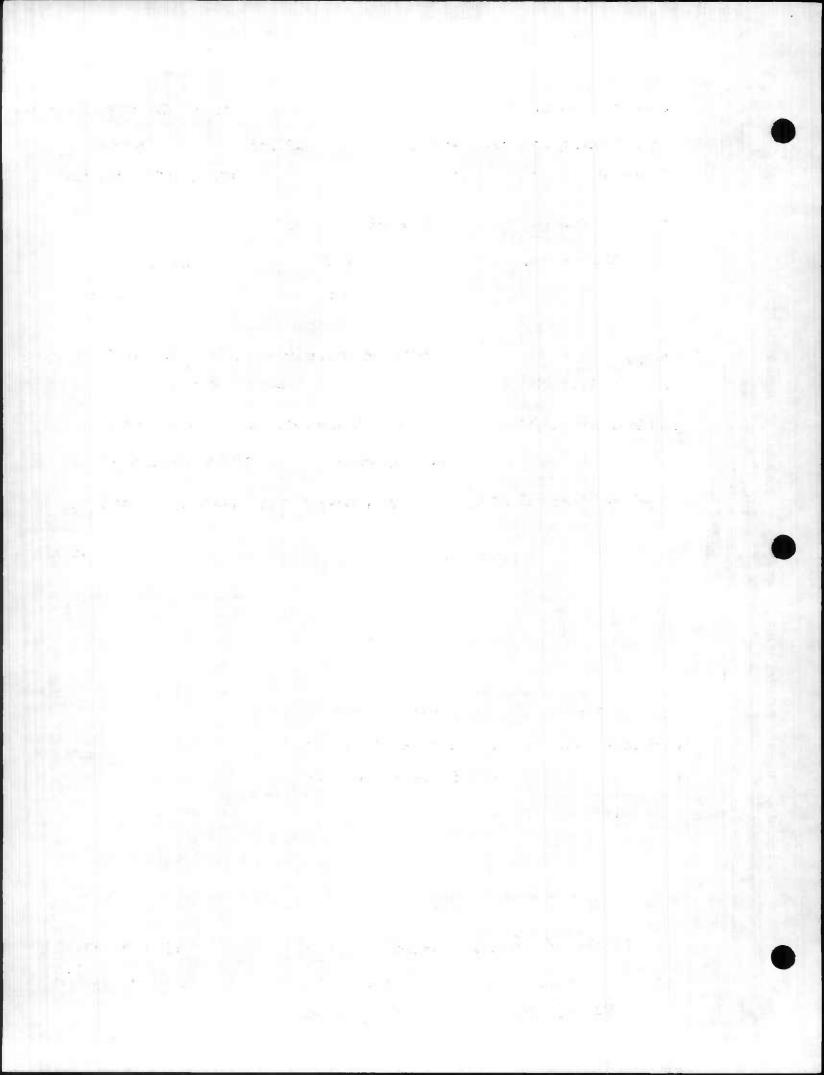
Important: If Item 27 is marked other than "natural", or items 29a and injury or other traumatic event, the Mental Examples 2006. 148 Williams Ave. Funeral 26537 United States American Indien, 12. Wes Decedent Ever in U,S.
Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 11. Merital Status Bleck, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0020 1 Yes 200 Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 18e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use ratired) (Specify only highest grade completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Dover Air Force B as e Heavy Equipment Operator Unknown 18. Mother's Nama (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be William Reichert Florence Reichert 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Kathleen Reichert/Wife WV 148 Williams Ave. Kingwood. 26537 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☑ Buriei 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 3/2/99 Philos Cemetery Westernport, MD 21. Signeture of Funeral Service Licenses 22. Nama and Address of Fecility Wan 20 Boal Funeral Home Westernport, MD 21562 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat end Deeth **Physician** /Medical Immediate Cause (Final pneumonia 3 days diseese or condition rasulting in daath) Examiner Due to (or as a consequanca of): Examiner physician end the burief-transit the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medicai Due to (or as e consequence of) 80 950 Po ed by the e Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4∑ Unknown atherosclerotic cardiovascular disease, be det Records, by 24b. Were eutopsy findings aveilabla prior to completion of ceuse of daeth? Completed 24e. Wes en eutopsy performed? diabetes mellitus, chronic renal failure page 2 has multi infarct dementia 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: funeral director, 25. Wes cese refarrad to medical Be 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: To 1 ☐ Yas 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28e. Dete of tnjury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Netural • Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Sulcide Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred et tha time, dete end plece, end due to the causa(s) and mannar as stated.

2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the tima, data end plece, end dua to the ceuse(s) end menner steted. 29e. Certifian Medicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signeture and title of partifier 29c. License number 29d. Deta signad (Month, Day, Year) D25759 February 27, 1999 30. Name end eddrass of person who complated causa of daath (Itam 23a) (Type, Print) 21520 Walter K. Naumann, M.D., PO Box 247, 106 Cemetery RD, Accident MD 31. Dete filed (Month, Dey, Year)
MAR - 2 1999

32. Ragistrer's Signeture

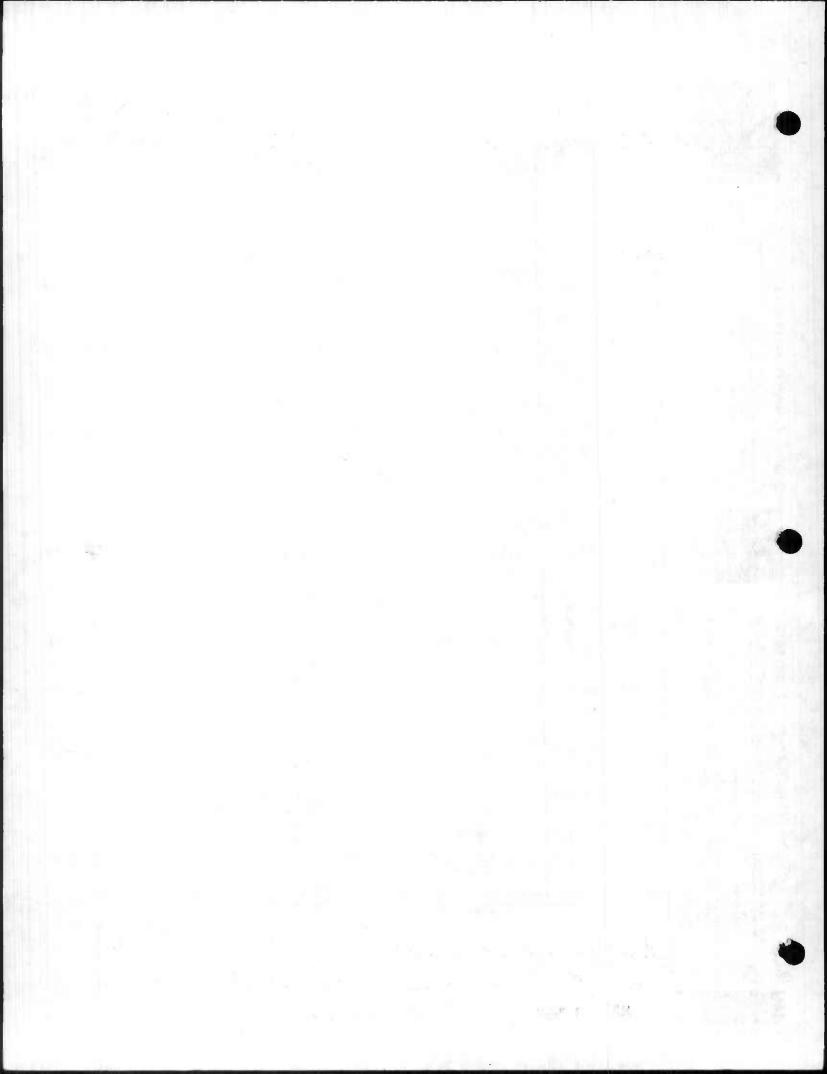
State Registrar



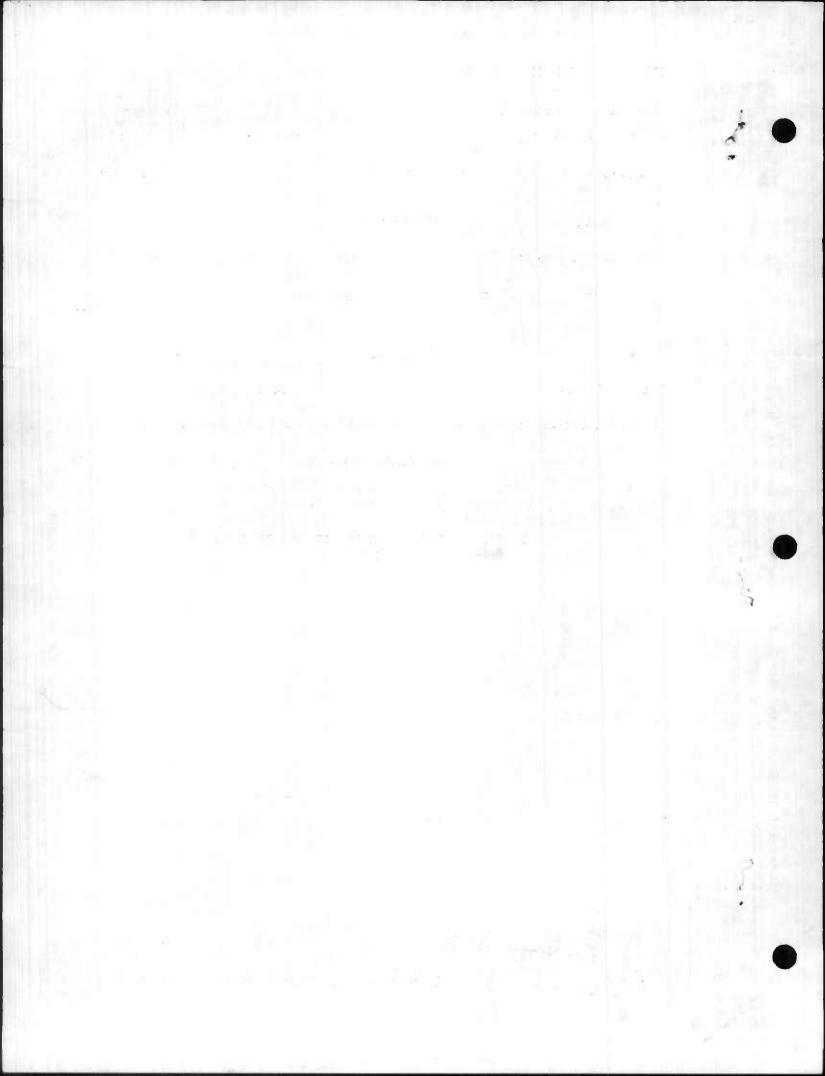
State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AM **Physician** Month Oliver Riggleman Harold, /Medical 4b. City, Town, or Location of Deeth 4e. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** memorial Garget Hospital Saklanu If Under 24 Hrs. 8 D Garnet 5. Social Security Number 7. Age (In yrs. last birthday) 68 Yrs. If Undar 1 Yaar 9. Birthplace (State or Foreign Country) 6 Sax Funeral Months Days Y1930 15 M 20 F 218 24 8147 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits "natural", or items 23a or 28a-f show Md Garrett Kitzmiller 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Vindex Rd 21538 USA Funeral death 12. Was Decedant Evar in U,S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Race - Amaricen Indian, Biack, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiena. Important: If Itam 27 Is marked other than "natural", or itea any Injury or other traumatic event, Its Medical Examines 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: Be Completed by SpecifiWhite 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Garrett Co. Highway Dept. County Roads Baltimore, Maryland 17. Father's Name (First, Middle, Last) Harry Riggleman 18. Mother's Neme (First, Middle, Maiden Surname)
Anna Lipscomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Edith Riggleman 103 Vindex Rd. Kitzmiller, Md 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Turner Cemetery Mar 5 99 Swanton Md 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
David A. Burdock
710 Church St. I Kitzmiller, Md 23a. Part.f. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** Infarction /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The law requiras that the death certificata be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the Due to (or as a consequence of) for use as Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, λq page 2 should be Completed 24b. Were eutopsy findings available prior to completion of ceusa of death? 24a. Was an autopsy performed? After this cartificate has 1 ☐ Yes 2 ☐ No of Vital Be 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) 1 Inpatient 2 ER/Outpatiant 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No s after dea... 27. Menner of Death Dete of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Division or Attending 5 Pending investigation Naturel 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours at To the Funeral D completely filled i Acceptifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) 30. Name and address of pe ceuse of deeth (Item 23a) (Type, Print) and MD Zwal 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State 3 1999 Registrar



		#23 PART I				ertificate d		2. Data of D		Veer	3. Time of Death	
cian lical	CAROI	LYN A. RO	BERTSON					Month MARCI	Day H 13. 19	Year 99	8:30 PM	
cai ier	4a Facility Name	(If not institution, g	iva streat and num	iber)				or Location of Dea	th 4c. County	of Death		
J	SACRED	HEART HO	DSPITAL				CUMBER		AL	LEGAN		
	5. Social Security		Sex 1□M 2\DF	7. Age (In yrs.	last birthda Yrs.	y) If Undar 1 Ya Months Da		in. (Month, D	ay, Year)	9. Birthp	place (State or Foreigntry)	
	219-44- Usual Residence			53	710.			Dec 2	1, 1945	MD		
	10a. State	10b. County		10c. Cit	y, Town or	Location				1	0d. Inside City Limits	
	MD	Allegan	У		Cumbe	erland					Y Yes 2 □ No	
	10e. Street and N					10f. Zip Cod			10g. Citizen of t		itry?	
Be Completed by Funeral Director	14707 Bourbon Street					215		/C'A- VN	USZ	ean Indian,		
	11. Marital Status	rried 3 Married	12. Was Dece	ces?	,5.	If Yes, specify (	(Specify Yes or N arto Rican, etc.)	Blac	ck, Whita,			
		4 ☐ Divorced	If Yes, Give Yaar or Da	•		1□ Yas 🎾	No Specify:		Specify	hite		
	/Sn/	Elementary/Secondary (U-12) College (1-4or 5+)					cupation ne during most of v tired)	working				
	Elementary/Sec						tired)	Torking				
	12 Tathara Name	12 7. Fathar's Nama (First, Middla, Last)					10 Markada A	Name (First, Middle	Own Ho			
		i (First, Middla, Las I. Hivick	1)							16)		
)		Name/Relationship	(Type, Print)		19h Ma	iling Address (St	eet and Number or	or (Skell		State. 7in	Code)	
		Roberts		ısband			on Street				502	
	20a. Method of Di	sposition		20b. F	Place of Dis	position (Name o		Date	20c. Location			
		Cremation 3   5 Other (Spec		tate		and Crema		03/18	Cumber	land.	MD	
1	21. Signatura of F	uneral Service Lio	nsee	1		22. Nama and Ad	dress of Facility					
	DY I	aholh	L. h	Airel	1		lli Funer land, MD	21502	P.A.			
	23a. Part1. Enter	the disease, or con art failura. List onl	notications that cay	used the deat	h. Do not e	enter the mode of	dying, such as card	liac or respiratory	arrest,		Approximate Interval Between	
							WITH HYPERT			R	Onset and Death	
n al er	Immediate Cause disease or condit resulting in death	ion	a			DISEASE						
	resulting in death			Due to (	or as a cons	sequenca of):						
	b									i		
	Sequentially list of if any, leading to	onditions, immediata		Due to (d	or as a cons	sequenca of):						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):											
	resulting in death) Last  Due to (or as a consequence of):									i		
			d									
	Part il. Other eign	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the ceuse of de			
	PULMONAR	Y EMPHYSEMA						10	Yee 2 No	3 Pro	bably 4 Unknow	
								24a Wa	s an autopsy	24b. W	ere autopsy findings	
								per	formad?	av	allable prior to implation of cause	
								45	Vac allan		death?	
	25. Was case refe	erred to medical					ge Diese of f	Teath (Charle act	Yes 2 No	11	Pres 2□ No	
	examiner?		Hospital:	patient 25	FR/Outpot	ient 3 DOA	Othor	Death (Check only g Home 5 Re		ner (Specia	(v)	
	27. Manner of Dea	ath	28a. Date o		28b. Time		njury at Work?		how injury occur		71	
	1 🖾 Natural 2 🗆 Accident	5 Pending investigation		i, Day Year)	Injun		Work/ 1 ☐ Yes 2 ☐ No					
Columnation:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be 28e. Place of building	of Injury - At h	ome, farm,	street, factory, off	ice	28f. Location City or T	(Street and Numi	ber or Run	al Route Number,	
			Donair	g, oto. (opoon	,,							
	29a. Certifier (Check only	1☐ Certifying P 2☐ Medicai Exa	miner: On the bas	sis of examina	wiedge, de ition and/or	ath occurred at th investigation, in r	e time, date and pla ny opinion, death o	ace, and due to the	e cause(s) and m	anner as a	tated. o the cause(s)	
	one) 29b. Signature an		and mann	er stated.			ense number		29d. Date signe			
	Lou. Signature and	PH	044	MN		250. ER	O.C.M.E.		MARCH			
	20 Nome :	· Jus	/	1 , 617	n 02-1 (T	o Drint\						
	30. Name and	The same of person who	completed cause				, Baltim	ore. Mar	vland 21	201		
	1. /	1 1 1 1 1	I VI VIII	7 Inchalle								
e	31. Date filed (Mo	IAR 1 9 19	99 32. Be	gistrar's Signa	atura							



		Decedent's Neme (First, Middle, L.	n ed l		Certificate of	Death	100000	Reg. No.			
nysici Medic	cal	KATHE	RINE SIPPL	E		41 Oh Tana	2. Dete of De Month FEBRU	Dey ARY 28,	Year 1999	3. Time of Death 9:45PM	
xamin	ier	4a. Facility Nama (If not institution, g CARRIAGE HILL -				4b. City, Town, or BETHE		h 4c. County MONTG			
neral		017-22-0051	Sax 1□M 2F 7. Age 1□M 2F 93	e (In yrs. lest b	irthdey) If Under 1 Year Yrs. Months Days			th by, Year) 5, 1905	9. Birthpied Country MISSO	e (State or Forei ) URI	
ie d at	tor	Usual Residence of Decedant  10e. Stete 10b. County MD MONTGOM				10d.	Inside City Lim				
and	Director	10e. Street end Number			10f. Zlp Code		10g. Citizen of Whet Country?				
MARLE		5215 CEDAR LANE			20814		U.S.A.				
, a	by Funerai	11. Maritel Stetus  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Tas 2 N If Yes, Giva Year or Detes:	ever in U,S.	13. Wes Decedent of If Yes, specify Cut	e - Amarican Indien, k, White, etc.					
	Completed	15. Decedent's 8 (Specify only highest g Elementery/Secondery (0-12)	rade completed)	on 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of work of the second life. DO NOT use retired						of Business/Industry	
		12 17. Father's Name (First, Middle, Las	t)	HOI	MEMAKER	18. Mother's Ne	me (First, Middle	OWN HO			
tic event,	To Be	WILLIAM CALEB SI	*			MARY LE			-/		
aume		19e. Informent's Name/Reletionship			b. Meiling Address (Stree					ode)	
r other traumatic		ARTHUR LAMBERT  20e. Method of Disposition	NEPHEW		3 WEST 9TH S		EW YORK,		IOUII ion - City or Town, Stata		
y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Spec			of Disposition (Neme of ery, cremetory or other plant MORA CEMET)		3/9/99	ST. JOS			
any injury or conce.		21. Signature of Fundral Service Lion		)	22. Name end Addr JOSEPH GAW	ass of Facility LER'S SOI					
ian ical iner	er	23a. Pent1. Enter the disease, or construction of the control of t	. Pre	evaca				1		tervel Betwaan	
night dall sit	i Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury									
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0		resulting In deeth) Last	d				-				
for use es		resulting In deeth) Last  Pert II. Other algnificant conditions		t not resulting	in the underlying cause g	ven in Pert I.	23b. Did	tobacco uee cor	ntribute to th	e cause of dea	
oe detached for use es	by Physician/Med	resulting In deeth) Last	contributing to deeth bu					tobacco uee cor Yes 2Å No			
2 should be detached for use es	by Physician/M	Pert II. Other algnificant conditions	contributing to deeth bu				24e. Wes		3 Probab	eutopsy finding	
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ral director, page 2 should be detached for use ex	To Be Completed by Physician/M	Pert II. Other algnificant conditions  25. Wes case referred to medical exeminer?	Hospitel:  28a. Dete of Injure (Month, Dey	nt 2 ER/O	by any CG.  utpetient 3 DOA Of Time of Injury Wo	26. Plece of De	24e. Wes perfect	en eutopsy ormed?	3 Probab  24b. Were eveile comp of dec	eutopsy finding ble prior to letion of causa sth?	
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itely filled in by the funeral director, page 2 should be detached for use ea	edical Certification: To Be Completed by Physician/M	Pert II. Other algnificant conditions    Chrmil	Hospitel:  28a. Dete of Injunction (Month, Dey building, etc.  28b. Place of Injunction (Month)  28c. Place of Injunction (Month)	nt 2 ER/O y Year) 28b.  ry - At home, fr. (Specify)  f my knowledg examination ented.	utpetient 3 DOA Of Imperiment of Injury Months of Injury	26. Plece of De her: 4 Nursing I rk? LYes 2 No	24e. Wesperfo	Yes 2 No  en eutopsy primed?  Yes 2 No  one)  dence 6 □Oth how Injury occurr  Street end Numb  ceuse(s) end me dete end plece, a  29d. Dete signed	3 Probab  24b. Were eveile comp of dee to provide the comp of the com	eutopsy finding eutopsy finding ble prior to letion of causa sith?  es 2 No  noute Number, e cause(s) y, Year)	

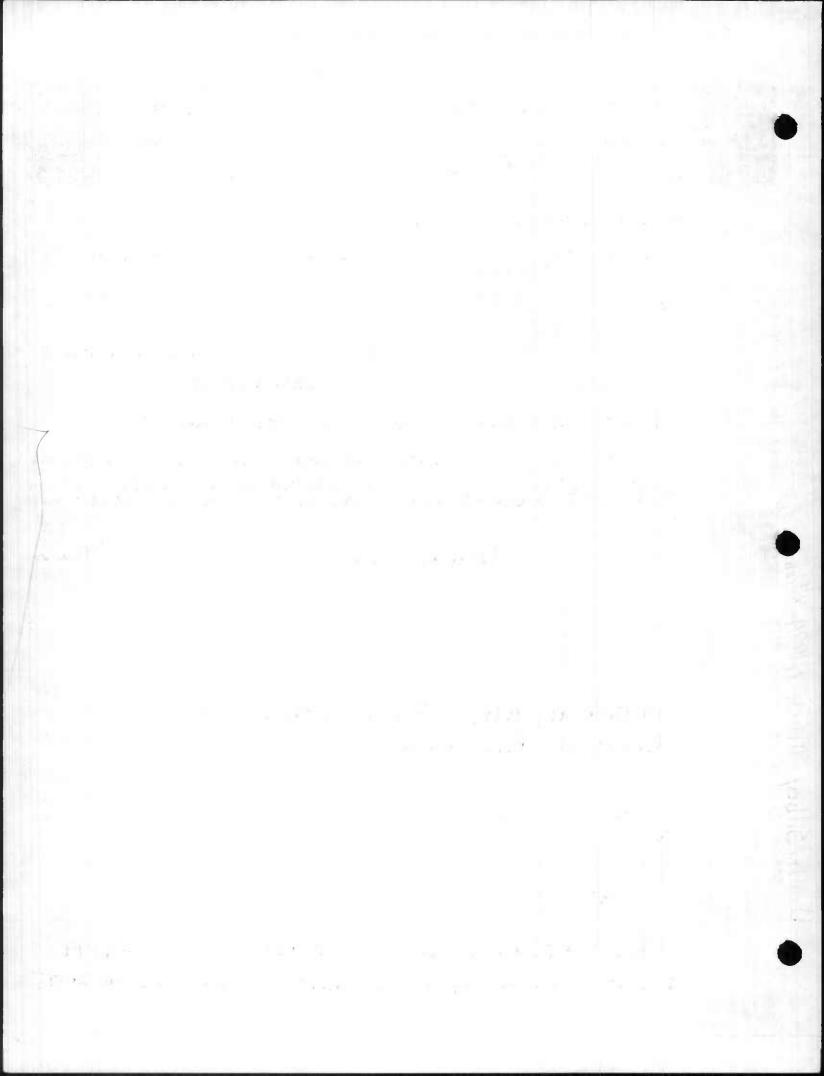
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month DOROTHY LEBMAN SILBEY MARCH 7, 1999 8:40 PM /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🗓 F 216-46-9260 86 Yrs. Director 1913 MASSACHUSETTS Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 X Yes 2 No Director MONTGOMERY MARYLAND POTOMAC 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 10409 GARY ROAD 20854 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Maritai Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 À Specify: WHITE 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry se filed within 7 tal Hygiene. d other than "r Elementary/Secondary (0-12) College (1-4or 5+) TEACHER D.C. PUBLIC SCHOOLS 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) and Mental H marked JOSEPH LEBMAN AGNES GOLDSMITH permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) RUTH PALOMBO WEISS (DAUGHTER 10409 GARY ROAD - POTOMAC, MARYLAND 20854 20b. Place of Disposition (Neme of cemetary, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Spedily) COMFORT CREMATORY 3/10/99 ALEXANDRIA, VIRGINIA 21. Signature of Funeral Servi DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852 Part1. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximata ntarval Betwo Physician /Medical Immediate Cause (Final disease or condition resulting in death) lears Emphy sema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of): Physician/Medical 2 Dua to (or as a consequence of): atten Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 Atrial 1 Yes signed by 2 No 3 Probably 4 Unknown Tachy cardia Pnevmonia 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? Recurrent Completed **Dage 2** certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yas 2 ☐ No 25. Was cese referred to medicei examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 是 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attec 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) affer a 4 Homicide To the Hospital o within 24 hours at To the Funeral Di Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print) Wisconsin Ave Chery Chase MD 20815 Scott Cohen 5454 MD 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature State MAR 1 0 1999

Registrar

Drothy Silbey March 7, 1999 Division of Vital Records, P.O. Box 68760.



State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death

**Physician** /Medical Examiner

Director

**Funeral** Director

rail, or items 23s or 28s-f show "natural", or el Hygiene.
d other than "natural

Funeral 72 hours after 21215-0020 à Completed Baltimore, Maryland Pages 1 and 2 should be fill ment of Heelth end Mentel Heart: If item 27 is marked other traumatic even **Physician** /Medical Examiner Examine ician and burial-transit physician street Physician/Medicai P.O. þ Records. Completed The law of Vital Be Certification: To this 27. Menner ot Deeth

1 Natural

2 Accident Division death. after 6 24 hours 29a. Certifier To the Hosp within 24 ho To the Fune completely fi

1. Decedent's Name (First, Middle, Last) 3. Time of Death 03.02.1999 11:00 PM ANNETTE LEVINE SILVERMAN 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death MONTGOMERY BETHESDA SUBURBAN HOSPITAL 8. Date of Birth (Month, Day, Year) 09.15.1911 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Days 1 M 25 F Months Hours NT 87 069.26.4914 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20852 6121 MONTROSE ROAD 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ②No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) CLOTHING SHOP MANAGER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) SARAH "UNKNOWN" ROBERT BUDIN 19a. Intormant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AMERICAN EMBASSY, ACCURA, US DEPARTMENT OF STATE WASHINGTON, DC 20521-2020 Harriet Lancaster/DAUGHTER 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete
4 Donation 5 Other (Specify) 3.7.99 FLUSHING, NY MOUNT HEBRON CEMETERY 21. Signature of Funeral Service Licenses 22 Name and Address of Facility ERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Ceuse (Final disease or condition resulting In death) Gastrointestinal Coumadin DXI Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Pneumonia 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 No 2 No 25. Wes case reterred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Inpatient

5 Pending Investigation 6 Could not be determined

28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of Injury

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as steted.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and menner steted. (Check only one) 29b. Signature and title of certifie ellie mo

D53244

29d. Dete signed (Month, Day, Year) March 3; 1999

Lillie, MD 11140 Rockville Pike#348 Rockville, MD 20852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Katharine

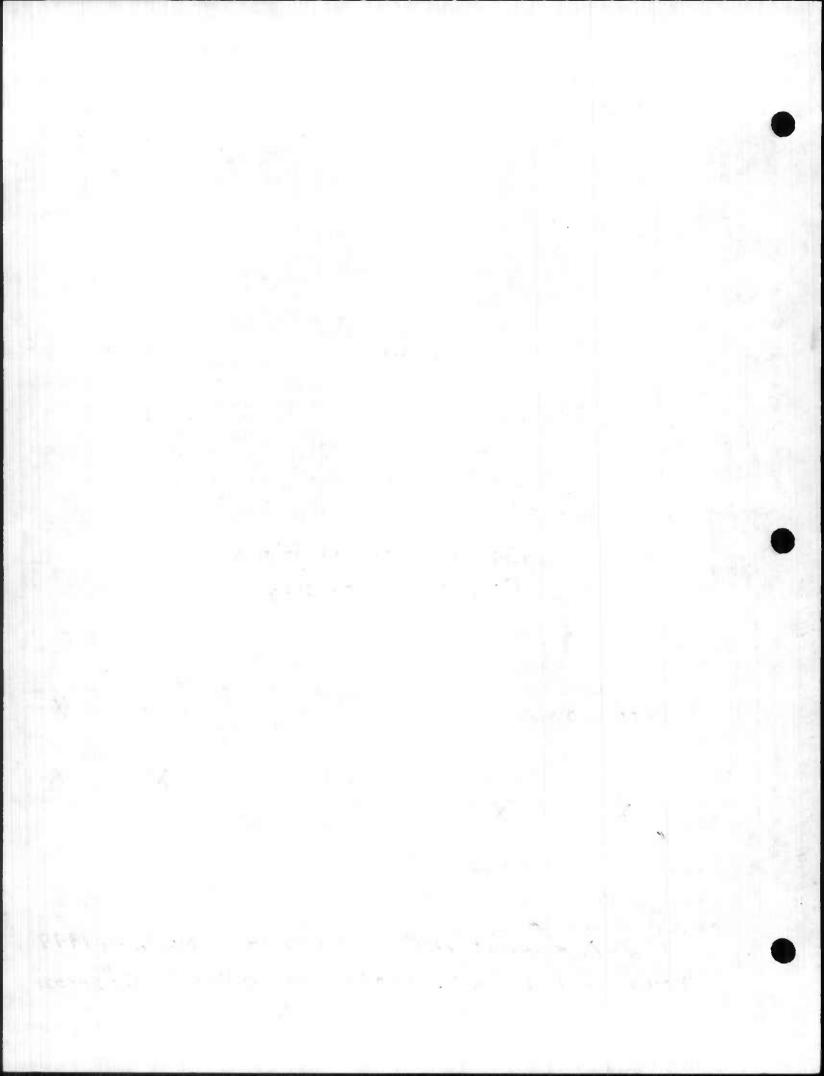
32. Registrar's Signeture

State Registrar

3 Suicide

4 Homicide

JERMAN, ANNIETE

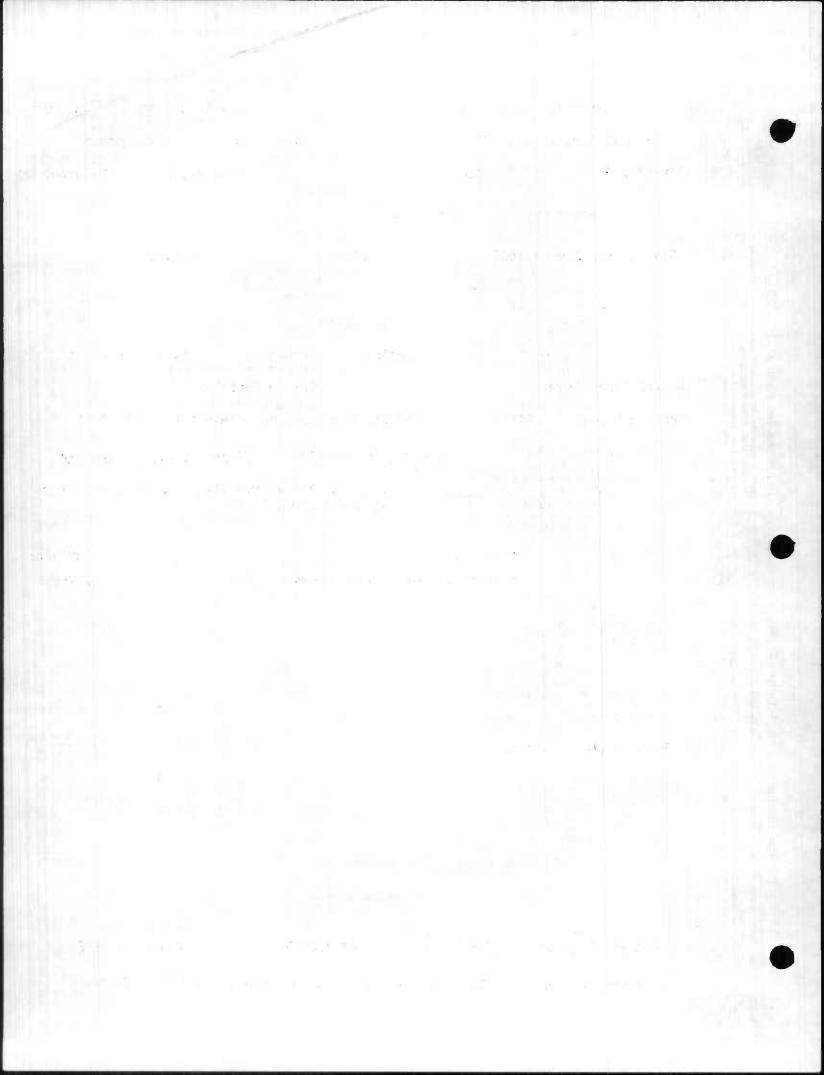


State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Data of Death **Physician** March 3, 1999 DAISEY ALDINE STOLLER 5:00AM /Medical 4b. City, Town, or Location of Death 4a Facility Nema (If not Institution, give streat end number) 4c. County of Deeth **Examiner** 4515 Willard Ave. #802S Chevy Chase Montgomery Hours Min. 8. Date of Birth (Month, Dey, Year) If Under 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Months Deys Yrs. 578-01-0257 83 24, 1916 Washington, DC **Director** Usual Residence of Decedent with the Marylend 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Chevy Chase 1 ☐ Yes 2 ☑ No Directo 10g. Citizen of Whet Country? 10a. Street and Number 10f. Zip Code Hygiene. other than "natures", or items 23a or vent, the Medical Examiner must be. 4515 Willard Avenue #802 20815 U.S.A. permit. Pages 1 and 2 should be filled within 72 hours after death 1 Department of Health and Mantal Hygiene. Important: if item 27 is merked other than "naturer, or items 23s any injury or other traumatic event, the Medical Examinar must bubble. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department Of Commerce U.S. Government 17. Fethar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Daniel Issac Stover Carrie Brubaker 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Carolyn Stover Sister 5480 Wisconsin Avenue, Chevy Chase, MD 20815 20b. Pieca of Disposition (Nema of cemetery, cremetery or other piece)
Baltimore / Washington
Crematory 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 3/6/99 Laurel, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signature of Funeral Service Licansae Joseph Gawler's Sons INC, 5130 Wisconsin Ave. UB 6 NW, Washington, DC 20016 23a. Part1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fntervel Between Onsat end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Arrythmia 1 Minute **Examiner** Arteriosclerotic Heart Disease 5 Years Examiner attending physician end for use es the burial-trensit deeth certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Physician/Medicai Due to (or es e consequence of) ed by the a 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown signed t Osteoporosis Division of Vital Records, by 24e. Wes en autopsy performed? 24b. Were autopsy findings evellable prior to Completed Polymyalgia Rheumatica completion of cause of deeth? page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director. 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Homa 5 🛱 Residence 8 ☐ Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Date of Injury (Month, Dey Year) funeral 28d. Describe how Injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: After 5 Pending 1 Neturel after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Straat and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 3 4 Homicide To the Hospital or within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end pleca, end due to the cause(s) and manner es stated. edicai completely 2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end placa, end due to the cause(s) end menner stated. (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certiller 000006025 March 4, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lawrence H. Schainker MD., 5401 Western Ave. NW Washington, DC 20015-2998 31. Dete filed (Month, Dey, Year) MAR 0 8 32. Registrar's Signeture State 1999 Deneva.

**DHMH 16 Rev 6/95** 

Registrar



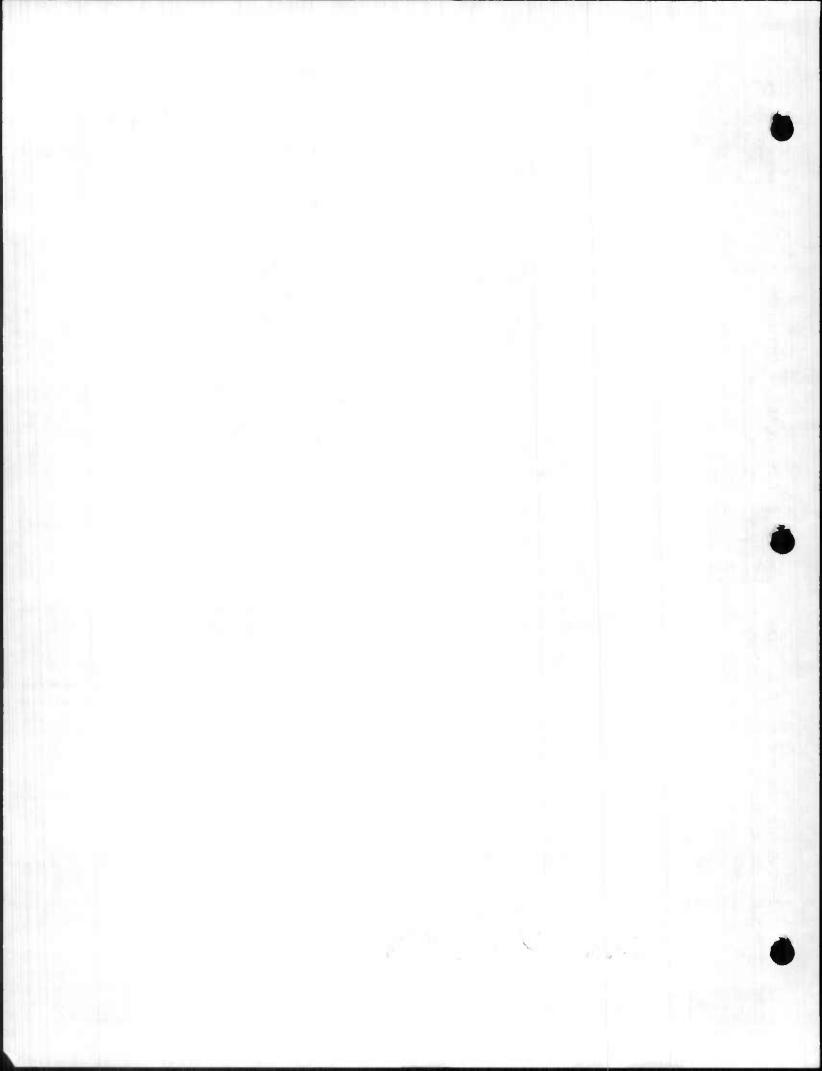
#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 9, 1999 9:00AM DR. PHILIP STRAX MAR. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner 7016 RICHARD DRIVE BETHESDA MONTGOMERY If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 110 M 2□ F Months Hours Director 90 NY 098-12-6884 Usuel Residence of Decedent with the Marylend 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo FL BROWARD HOLLYWOOD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3850 WASHINGTON ST. 33021 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black. White, etc. parm. Pages 1 and 2 should be filed within 72 hours effer on parment of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: þ 3 N Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 5+ PHYSICIAN RADIOLOGIST 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be JACOB STRAX MOLLY (UNOBTAINABLE) 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RITA WEIL / DAUGHTER 7016 RICHARD DR., BETHESDA, MD 20817 other 1 20b. Place of Disposition (Neme of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 6 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State 4 □ Donation 5 □ Other (Specify) BETH MOSES CEMETERY 3/11/99 LONG ISLAND, NY 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 DANIEL SIMONS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onsat and Death Physician Immediate Cause (Final disease or condition resulting In deeth) /Medical METASTOTIC PROSTATE CANCER Examiner Due to (or es a consequence of): Examiner LUNG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): and LIVER CANCER Box 68760 physician 2 Physician/Medical certificate 96 Due to (or as a consequenca of) 2 attending ö signed by the at id be detached for Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy Completed peen 2X No 1 Yes 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician:
24 hours efter death.
 Funeral Director: After this certific. funeral director, Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) RESTDE P 1 Yes 2 No 1 Innatient 2 ER/Outpetient 3 DOA Certification: 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) completely filled in by 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted.

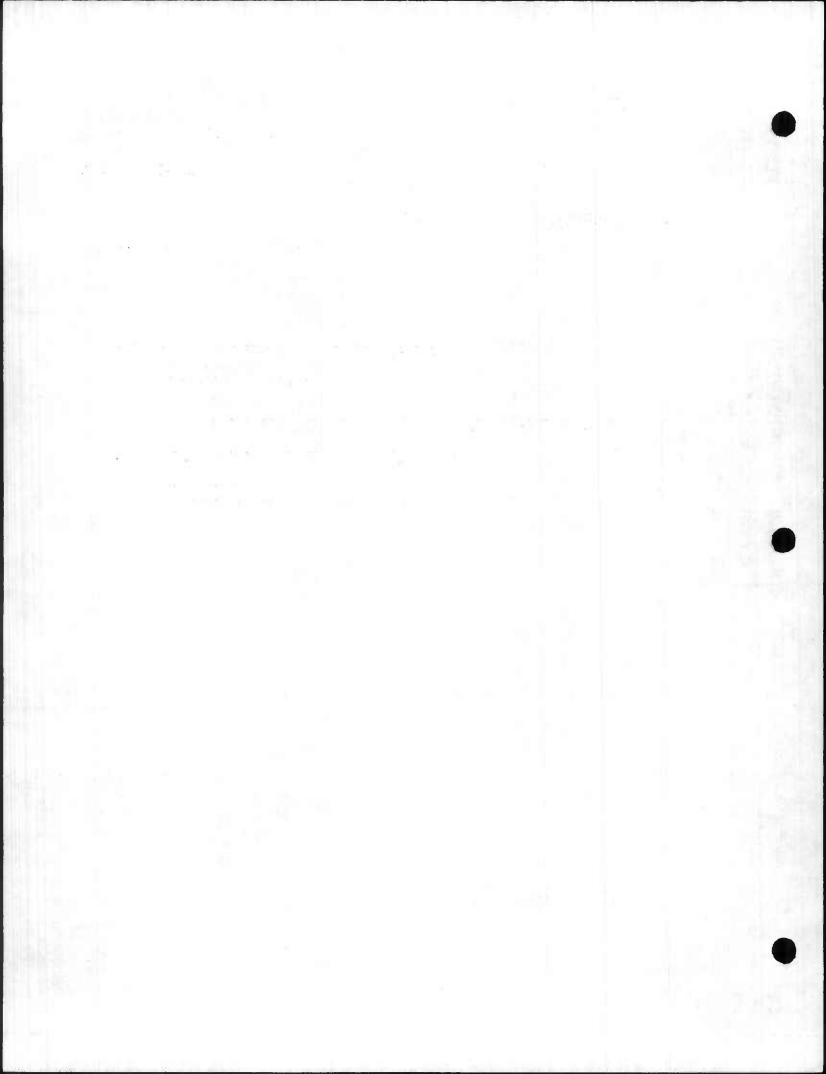
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and mannar stated. Medical To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of confilm 29c. Licensa number MAR. 9, 1999 D18813 30. Name end address of person who completed cause of deeth (Item 23a). (Print) #304, SILVER SPRING, MD 20902 IRA TAUBER, MD, 10301 GEORGIA AVE., 31. Date filed (Month, Dey, Year) MAR 1 0 32. Registrar's Signature State 1999 Zener

Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	Decedent's Neme (First, Middle, Las	st)	Ce	rtificate of	Dealli	2. Dete of De		3. Time of Death			
sician edical	LEWIS	STREPPA				MARC	10	999 0200			
miner	4e Facility Neme (If not Institution, give		TCM HOC	TMAT	4b. City, Town, or		on of Deeth 4c. County of Deeth				
ı	SHADY GROV  5. Social Security Number 6. Security N		In yrs. last birthday	PITAL  If Under 1 Year	If Under 24 Hrs	VILLE  8. Dete of Bir	th	NTGOMERY  9. Birthplaca (State or Fore			
	058 16 0594		Yrs.	Months Days	Hours Min	APRIL .	0,1917	NEW YORK			
	Usual Residence of Decedent  10a. Stete 10b. County			10d. Inside City Lim							
or or	MD. MONTGOME			1 Yes 2							
reci	10e. Street and Number		10g. Citizen of What Country?								
event the Medical Examiner must be notified at Be Completed by Funeral Director	29 GOSHEN COURT		UNITED STATES								
	11. Meritel Stetus  1 Never Merried 2 Merried  3 Widowed 4 Divorced	Armed Forces?	Yes 2 No WW II 1 Yes 2 No			Specify Yes or No to Rican, etc.)	14. Rece Black Specify:	- American Indien, k, White, etc. WHITE			
	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usuel Occu kind of work done DO NOT use ratin	pation during most of wo	orking	16b. Kind of Bus	siness/Industry			
	Elementary/Secondery (0-12)	College (1-4or 5+)		DO NOT use rating L RECORDS			HOSPI	ΤΔΙ			
	17. Father's Neme (First, Middle, Last)		HEDION	LILLOONDO			, Maiden Sumeme				
	Vincenzo Stre		DiBartolomeo								
	19e. Informent's Neme/Relationship (7	Stete, Zip Code)									
	GEORGIANA J. STR			OSHEN COL	JRT, GAIT						
ı	20e. Method of Disposition 1 ☐ Buriel 2 🔀 Cremetion 3 ☐			metory or other ple		Dete		City or Town, State			
ı	4 Donetion 5 Other (Specify			ITAN CREM		3/9/99	ALEXANDE	CIA, VA.			
	21. Signeture of Funerel Service Licensee  22. Name end Address of Fecility  MURIEL H. BARBER FUNERAL HOME  P.O. BOX 5038, LAYTONSVILLE, MD. 20882  23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,  Approximate										
	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line.  Immediate Cause (Finel disease or condition resulting in deeth)										
	tosoling in booting	Du	e to (or es a conse	quence of):							
	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury										
	Cause (Disease or Injury thet initiated events resulting In death) Last	Due to (or as a consequenca of):  d.									
	Pert II. Other significant conditions co	ontributing to death but n	not resulting to the	underlying cause g	iven in Pert I.	23b. Did	tobacco usa con	tributs to the causs of de			
2							1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐				
Palalalana							en autopsy ormed?	24b. Were eutopsy findin available prior to completion of cause of death?			
				35.00		10	Yes 20 No	1 ☐ Yes 25 No			
3	25. Was case referred to medical exeminer?	Hospitel: 🗸		0	hor	eth (Check only					
	27. Menner of Deeth 1 Naturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Yo	2 ER/Outpatie 28b. Time ( fnjury	of 28c. Inju	4 U Nursing	1	dence 6 Other				
	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, st Specify)	28f. Location ( City or To	8f. Location (Street end Number or Rural Route Number, City or Town, Stete)						
Medical Certification:	29e. Cartifier (Check only one) Certifying Phy	rsician: To the best of miner: On the basis of ex and menner stated	aminetion and/or in	th occurred et the to exestigation, in my	ime, dete end plac opinion, death occ	e, and due to the urred et the time,	cause(s) and mer dete end pleca, a	nner es steted. nd due to the cause(s)			
300			29d. Date signed (Month, Dey, Year)								
	29b. Signature and title of certiller		2				MARCH 6, 1				



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MARCH **Physician** 8 1999 SELMA WATTS SCHELLS 9:50 PM /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner CORSICA HILLS NURSING CENTER CENTREVILLE QUEEN ANNE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplaca (Sta (Month, Dev. Year)
JULY 18, 1918 MARYLAND 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplaca (State or Foreign **Funeral** 1□M 210 F Months Days Hours 219-14-3561 80 Yrs. **Director** Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours eftar deeth with the Manyland nent of Health end Mentel hygiens. Ant: If item 27 is marked other than "naturel", or items 23e or 28e-f show unt; If item 27 is marked other than "nature must be notified at uny or other traumatic event, me Medical Exp. since must be notified at 10a State 10d. inside City Limits 10b. County 10c. City. Town or Location MD QUEEN ANNE CENTREVILLE Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 ARMSTRONG STREET 21617 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 DNo If Yes, Give Year or Dates: 14. Race - American Indien, Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify: þ 3Ñ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be CHARLES DAYTON WATTS ANNABELLE COOPER 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 313 FOX MEADOW ROAD, QUEEN ANNE, MD 21657 ALICE S. ENGLE / DAUGHTER 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or OLIVET CEMETERY 3-12-99 ST. MICHAELS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as consequence of) Examiner DRUMBKIA law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) d for use es t signed by the e Pert II, Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24e. Was an autopsy performed? page 2 s Sec 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifics funeral director, 25. Was case referred to medical examiner? 26, Place of Death (Check only one) Be Nursing Home 5 Residence 8 Other (Specify) Other: or death. 1 ☐ Yes 2 No Certification: To 1 inpatient 2 ER/Outpatient 3 DOA 28c. injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending investigation 1 Yes within 24 hours after dea To the Funeral Director completaly filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

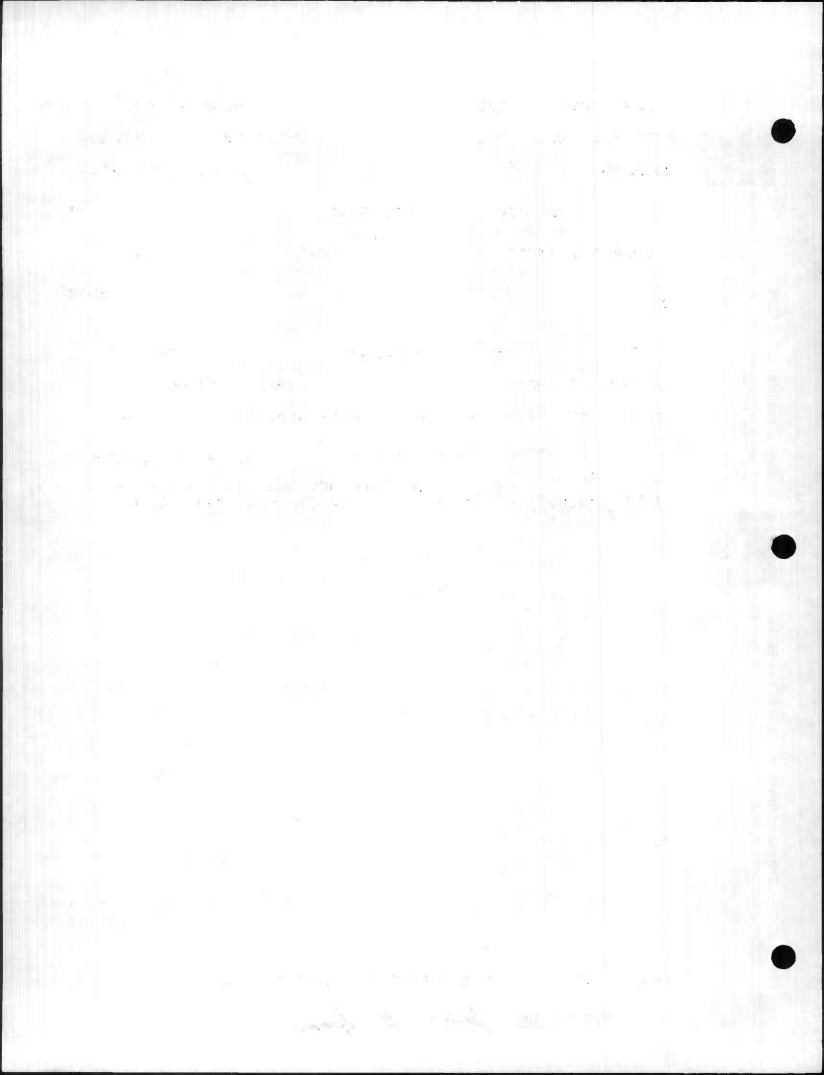
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) \$ 29b. Signature and title of certifier 29d. Date signed (Month, Dev. Year) 29c. License number 2 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATHLEEN HOEY, M.D., 207 N. LIBERTY STR, CENTREVILLE, MD 21617

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature



Sporks

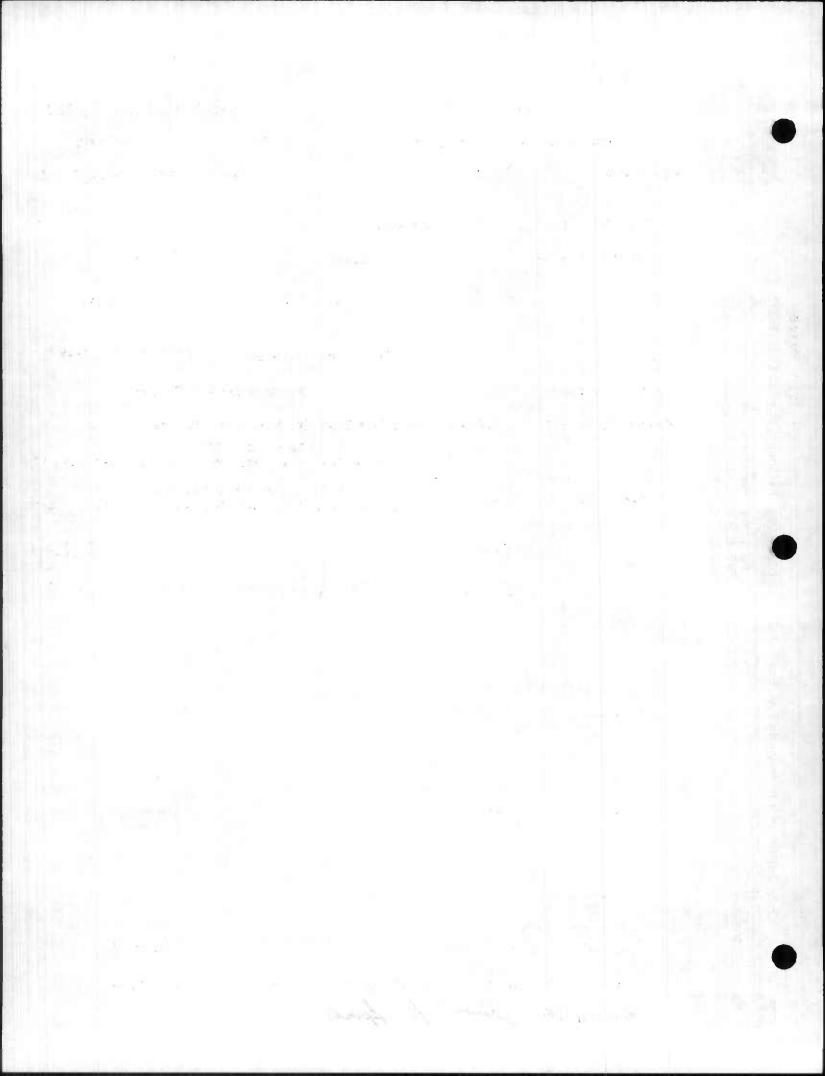


#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death		Reg. No.	05010		
	1. Decedent's Neme (First, Middle, Last)	2. Dete of De	eth	3. Time of Deeth		
Physician	GLORIA ALICE SMITH	Month	Dey Ye			
/Medical		Marcl vn, or Location of Deat				
Examiner						
	4	ston		albot		
Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Months Deys Hours	Min. 8. Dete of Bir (Month, De	th y, Year) 9.	Birthplace (State or Foreign Country)		
Director	166-26-0555 1 1 M 2LXF 65 Yrs.	March !	5, 1934 H	Pennsylvania		
2	Usual Residence of Decedent			404 1 14 00 11 2		
ahow Mar	10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits		
a or 28a-f show De notified at	Maryland Talbot St. Michaels			1 ☐ Yes 2√ No		
or 28a-f	10e. Street end Number 10f. Zip Code		10g. Citizen of What Country?			
23a o	1207 Washington Dr. 21663		U.S.A.			
al, or items 23a or 23a-f sho Examiner must be notified at by Funeral Director	11. Men'tal Status 12. Wes Decedent Ever in U.S. 13. Was Decedent of Hispenic Orig	gin? (Specify Yes or No	- 14. Raca - A	American Indien,		
natural, or items dical Examinat my sted by Funer	Armed Forces? If Yes, specify Cuban, Mexican,	, Puerto Rican, etc.)	Black, V	Vhite, etc.		
h, or	3 ☐ Widowed 4 ☑ Divorced Yeer or Detes:		Specify:	White		
natural', polical Exi	15. Decadent's Education 16e. Decedent's Usuel Occupetion		16b. Kind of Busine	ess/Industry		
	(Specify only highest grade completed)  (Give kind of work done during most life. DO NOT use retired)	of working		,		
than than	Elamantary/Secondary (0-12) College (1-4or 5+)		Enviormer	ntal Concern		
Contract	12 Administrative Assi. 17. Father's Neme (First, Middle, Last) 18. Mother	STANT r's Neme <i>(First, Middle</i>		ital Concein		
arked out atic ever To Be		7.11				
marked other	Freeman Stevanus Marg	aret Louis				
E III	19a. Informent's Neme/Reletionship (Type, Print)  19b. Meiling Address (Street and Number)	r or Rural Route Numb	er, City or Town, Sta	ta, Zip Code)		
whealth end Mental Hygiene. Item 27 is marked other than other treumatic event, the M To Be Comp	Sharon L. Griffith Daughter P.O. Box 1055 St. I	Michaels, N	Maryland 2	21663		
T of He	20e. Method of Disposition  12 Buriel 2 Cremetton 3 Removel from State  20b. Place of Disposition (Nama of cemetery, crematory or other placa) Mare	oh 9 1999	20c. Location - City	y or Town, Stete		
orto nt: If I	1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify)  Woodlawn Memorial Park		Easton	Maryland 2160		
Department of Important: If it eny injury or page.	21. Signeture of Funeral Servica Licansee 22. Neme end Address of Fecility		Das ton,	mary rand brown		
Departr Importu eny Inj pnce.	Harrison E. Leo	nard Funera	al Home			
	312 S. Talbot S 23a. Penti. Enter the disease, or complications that coused the deeth. Do not enter the mode of dying, such as in	t. St. Micl	naels, Mar	ryland 21663		
	23a. Pert1. Enter the disease, or complications that coused the deeth. Do not enter the mode of dying, such as shock, or heart feilure. List only one couse on each line.	cerdiec or respiretory e	rrest,	Intervel Between		
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Medical	Immediate Ceuse (Finel disease or condition resulting In deeth)  e. Sepsis  Due to (or es a consequence of):  b. Chronie obstanting pulm			2 days		
aminer	resulting In deeth)  Due to (or es a consequence of):		3	U		
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physician end as the buriel-transit edical Examiner	Sequentielly list conditions, if eny, leading to immediate causa. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es a consequence of):  Due to (or es a consequence of):					
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cate has been signed by the ettend, page 2 should be deteched for us.  Completed by Physiciary						
should should		24a. Wes	an autopsy 2 ormed?	4b. Were eutopsy findings evailable prior to		
2 sh				completion of cause of death?		
age age		10	Yes 2000	1 ☐ Yes 2 ☐ No		
certificate hes rector, page 2 Be Comp		of Death (Check only	one)			
certific irector	examiner?	rsing Home 5 Res		(C===#4)		
this of ral dire	1 Yes 2 No 12 Inpatient 2 ER/Outpetient 3 DOA 1 Nu 27. Menner of Deeth 28e. Dete of Injury 28b. Time of 28c. Injury at		how injury occurred	Specily)		
After	27. Menner of Deeth  1 Naturel 5 Pending (Month, Day Year)  1 Nestination Investigation  28e. Dete of Injury (Month, Day Year)  28b. Time of Injury (Work?  1 Yes 2 I					
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Plet Plet						
Tott	29b. Signeture and title of conifier 29c. License number		29d. Date signed (A	Month, Day, Year)		
	1/mm 1/hmm 103974	7	3/6/9	7		
	30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)		1-1	/		
		agton Ma	rland 010	201		
	David G. Oliver M.D. 503 Dutchmans Lane E. 31. Dete filed (Month, Day, Yeer) 32_Registrer's Signeture	aston, war	rland 216	OUT		
State						
Registrar	MAR 0 8 1999 Show 13. Sparks!					

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day SWEITZER 1999 AMTEL MARCH 11 6:00 AM 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 21320 TANYARD ROAD PRESTON CAROLINE If Under 24 Hrs. 8. Data of Birth
Hours Min. APR. 19,1919 If Undar 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Days 1⊠M 2□ F 79 TNOTANA Yrs 213-16-7798 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits tX Yes 2 No CAROLINE PRESTON 10g. Citizen of What Country? 10f. Zin Code 21320 TANYARD ROAD 21655 USA 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, atc. 1 X Yas 2 □ No WW II If Yes, Give Year or Dates: 1 Navar Marriad 2 Married 1 ☐ Yes 2 ☒ No WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) -0-OWNER/OPERATOR CANNING COMPANY 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maldan Sumama) SWEITZER, SR. LOIS OIDA ROBERTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) THELMA H. SWEITZER/ WIFE 21320 TANYARD ROAD, PRESTON, MD 21655 20b. Place of Disposition (Neme of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Spacify) SHERWOOD CEMETERY 3-14-99 SHERWOOD, MD 21. Signature of Funaral Service License 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Interval Betwaan Onset and Death weeks Carcinoma Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown 24a. Was en eutopsy performed? 24b. Were autopsy findings aveileble prior to & isees complation of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only ona)

**Physician** /Medical Examiner

> the signed by t

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Hoepital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica

To the Hospital of within 24 hours a To the Funeral D

filled in by the

by

Completed

Be

P

Certification:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

tem 27 is marked other than "nature!", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be lited within 72 hours after. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or ther any injury or other traumatic available.

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records. P.O.

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death

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10a. Stata

MD

10e. Street and Number

12

ALBERT

Director

Funeral

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disease or condition resulting in death) Examiner sician and burial-transit Sequentielly list conditions, if any, leading to immediate ceuse. Enter Undarfying Cause (Disease or Injury that initiated events resulting in death) Last physician at the burial Physician/Medical BS

Immediate Cause (Final

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case referred to medical 1 Yas 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work?

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No

29a. Certifie

Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) and menner as steted.

2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29c. Licensa number

29b. Signature 479 title of

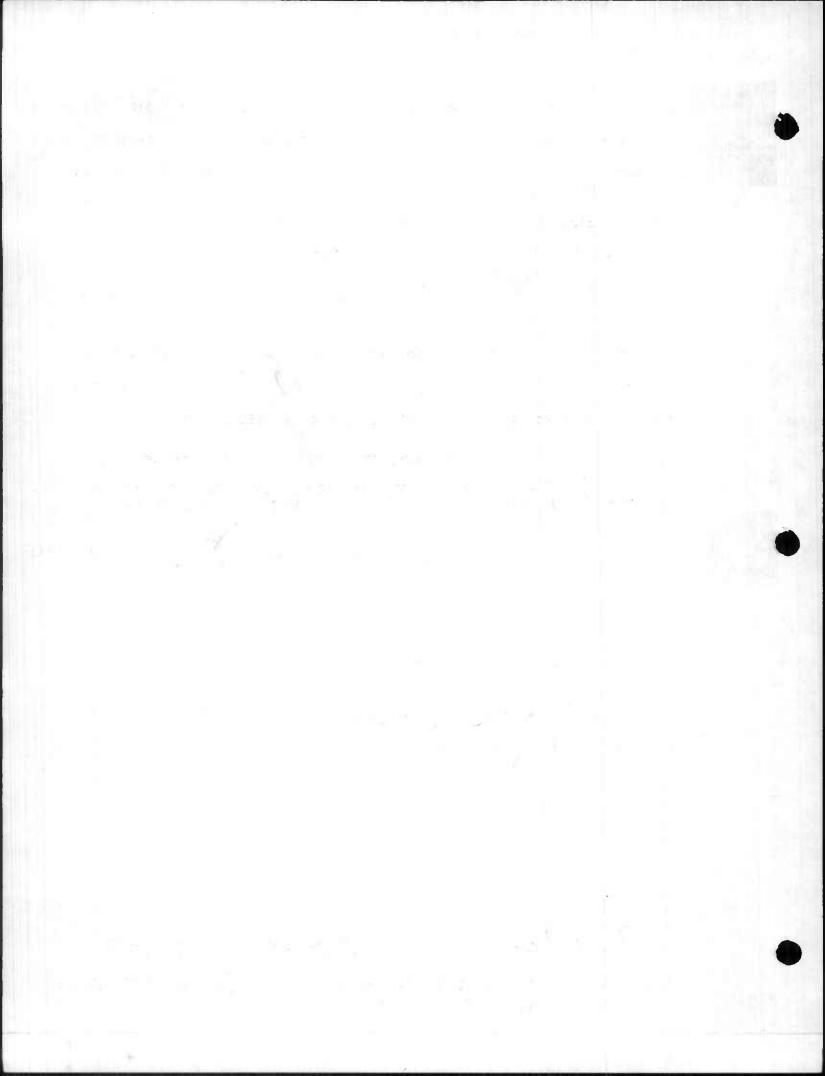
29d. Date signed (Month, Day, Year)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

30 Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Dutchnans Vid ~ 503 31. Date filed (Month, 32. Registra s Signeture

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Deeth 3. Time of Death Month 3 **Physician** NANCY SHELLEY 99 1836 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER Birthplace (Stata or Foreign Country) If Under 24 Hrs. Hours Min. If Undar 1 Year 8. Data of Birth (Month, Dey, Yeer) 1-13-36 5. Sociel Security Number 7. Age (in yrs. last birthday) 1□ M 2 F **Funeral** Deys Months 63 Yrs. 171-28-9384 Director Usuet Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or itams 23a or 28a-f ahow odical Examiner must be notified at 1 Yas 2 No Director MD. WORCESTER BERLIN 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21811

13. Was Decedant of Hispanic Origin? (Specify Yes or Noif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 166 SANDYHOOK Funeral S. A. 14. Race - American Indian, 12. Wes Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yas 2 No
If Yes, Give
Year or Dates: Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mentel Hygiena. Important: If Rem 27 is marked other than "natural", or its any injury or other traumatic avant, the Modest Experiment. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 à 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Neme (First, Middle, Maiden Surnama) 17. Father's Neme (First, Middle, Last) R. MCQUADE JOHN SIGRID Α. JUDEEN 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 166 SANDYHOOK BERLIN, Mp. GEORGE R. SHELLEY 21811 20b. Place of Disposition (Name of cematery, crematory or other placa) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stete
4 ☐ Donation 5 ☐ Other (Specify) SALISBURY CREMATORY 3-8 4 Donation SALISEURY, 22. Nama and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD. ULLRICH FUNERAL TOME BEY
23a. P. M. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Deeth **Physician** Immediate Ceuse (Finel disaese or condition resulting in deeth) /Medical Examiner Examiner MARU Trong attending physicien end for use as the burial-transit that the deeth certificate be axecuted Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 3 1 Yes 2 No þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en autopsy performed? Completed 1 Yes 2€ No 1 ☐ Yes 2 No 25. Was cese referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) Certification: To 1 Yes 2 No 1- Inpatient 2 ER/Outpetient 3 DOA # 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 1 Di Maturei or Attending 5 Pending 1 ☐ Yes 2 ☐ No Invastigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. edicai 29a. Certifier (Check only one) within 2 To the F å 29c. Ligense number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deal (Them 28e) (Type, Print)
4714 Healthway Drie Berlin, WD 21811 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth FEBRUARY 26 1999 **Physician** /Medical 4a. Fecllity Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign Country) **Funeral** 100 M 2□ F 219-62-8635 Usuel Residence of Decedent Yrs. Director 10a. Stete 10b. County 10d, Inside City Limits Wor 1 Yes 2 No Director 10f. Zip Code 10g. Cifizen of Whet Country? 12. Wes Decedent Ever In U.S. Armed Forces? 21863 Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or item any injury or other treumatic event, the Medical Enameration. 1 ☐ Never Merried 2 Merried 1 ☐ Yes 2 No If Yes, Give Year or Detes: Specify: Black 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 12 12. GFQGE.

17. Fether's Neme (First, Middle, Last) Ne - WOTKER Umber James phockley 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Addrass (Streat and Number or Rural Route Number, City or Town, Stete, Zip Code) e 310 Purvel S

20b. Piece of Disposition (Name of cometery, cremetry or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ABuriel 2 Crametion 3 Removal from State Cemotary 3-5-99 SNOW Hill Md. Jennic Smith Funeral Home 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Addrass of Facility Be NNic 21. Signature of Funerel Service Licensee Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock of heart failure. List only one cause on each line. Pocomoke City, md, 21851 **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in death) MASSIVE WEMOLOTYSZS Examiner Examiner Ruprunt Sequentielly list conditions, if eny, laading to immediate ceusa. Entar Undarlying Causa (Disaasa or Injury that initieted events rasulting in deeth) Lest HYPERTENSION Physician/Medical PULMARAY FEBRUSTS Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ ate has been signe page 2 should be 24b. Were eutopsy findings evelleble prior to completion of cause of death? Completed 24a. Was en eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Medical Certification: To 1 Yes 2No Inpatiant 2 ER/Outpetient 3 DOA 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accidant 3 Suicide 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Steta)

Records, P.O. Box 68760, of Vital the Hospital or Attending Physician: Division

284-1

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Baltimore, Maryland 21215-0020

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this certificate

After

State Registrar

28e. Plece of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 | Homicida Certifying Physician: To tha best of my knowledga, daath occurred et the time, deta end plece, end dua to the cause(s) end mennar es statad.

2 Medical Examiner: On the basis of exeminetion end/or invastigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner statad. 29a. Cartifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 10046080

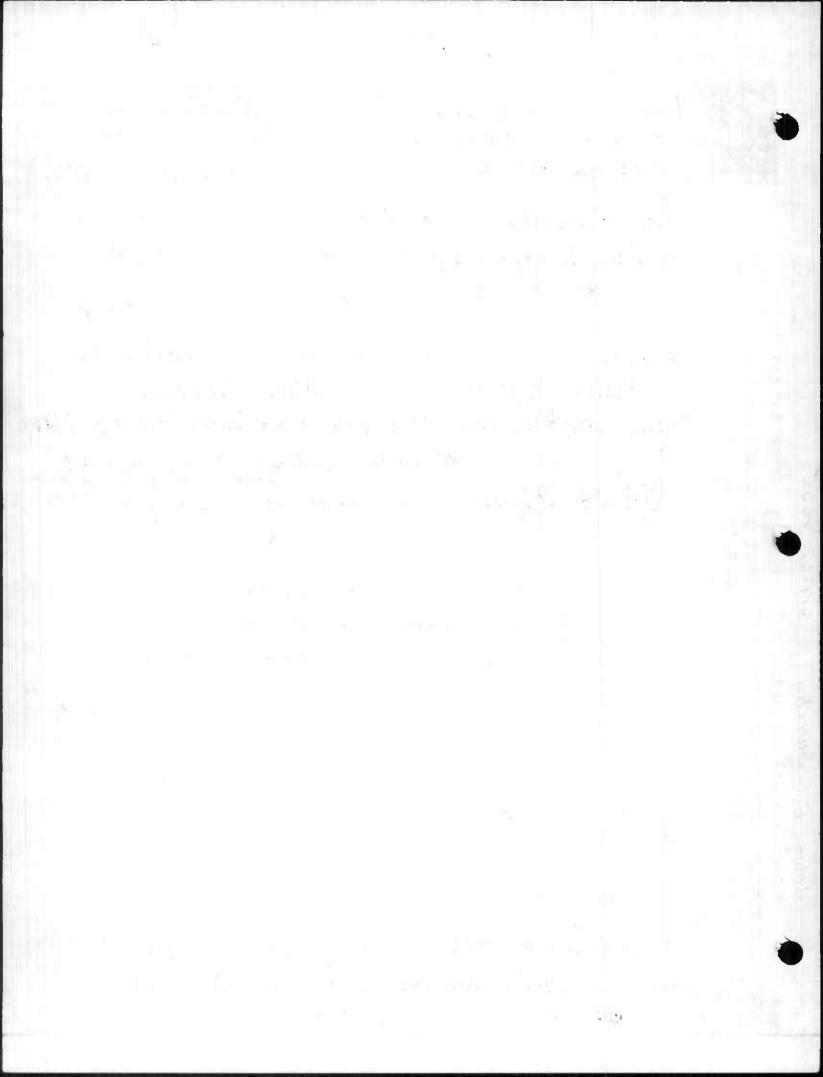
30. Name and eddrass of person who complated cause of deeth (Item 23a) (Type, Print)

ROBERT T. CHASSE, M.D

Station #379. 100 E, CARROLL STREET,

31. Dete filed (Month, Dey, Year)

MAR 0 8 32. Registrer's Signeture



State Registrar

31. Dete filed (Month, Day, Year)

Gary L. Wagoner,

M.D.

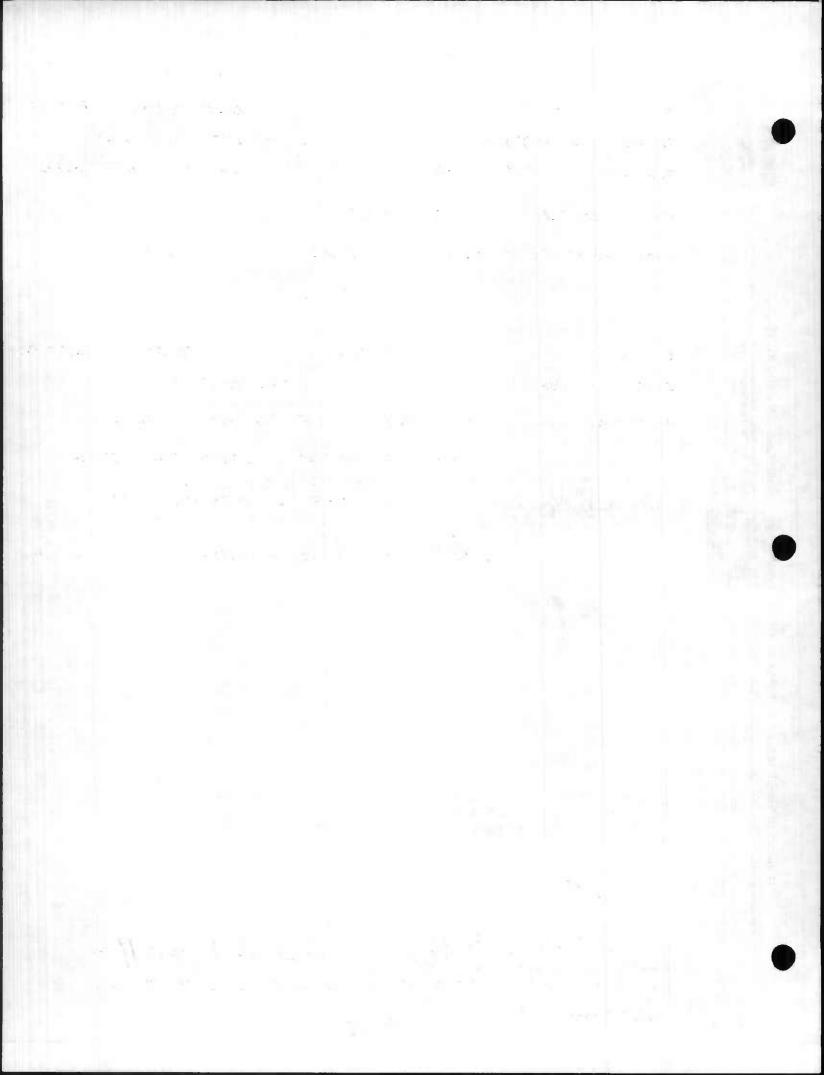
32. Registrar's Signeture , december

925 925 BISHOP WALSH DRIVE, CUMBERLAND, MD

21502

Box 68760.

Division of Vital Records,



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ZOLA LARUE SHRINER FEBRUARY 25 1999 2:45 A.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Months Hours Yrs. 214 07 1992 82 AUG 7 1916 PENNSYLVANIA **Director** Usual Residence of Decedent the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. Stata 10b. County man be notified at 1 X Yas 2 No Director MARYLAND ALLEGANY MT. SAVAGE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15128 MT. SAVAGE ROAD 21545 U.S. permit. Peges 1 end 2 should be filed within 72 hours after death 1 Department of Heelth end Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must place. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Year or Dates: 14. Race - American Indian, 11. Meritai Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: p 3 Widowed 4 Divorcad WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 11 HOMEMAKER OWN HOME 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be CLARENCE O'NEAL SUSIE SKIPPER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) DONALD SHRINER / HUSBAND 15128 MT. SAVAGE ROAD, MT. SAVAGE, MD 21545 20b. Place of Disposition (Name of cemetery, crematory or other pleca) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State SAVAGE METHODIST CEM 2/28/99 MT. SAVAGE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility SOWERS FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilura. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final a. Hepatic Failure

Due to (or as a consequenca of): disease or condition resulting in death) Examiner Examiner Leukemi physician and s the buriel-transit the death certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 80 980 signed by the e 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records, þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? certificate hes b irector, page 2 s 1□ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 12 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending efter death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident n 24 hours efter des ne Funerei Director pletely filled in by th 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and menner as stated. edical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) February 30. Nama and address of person who completed cause of death (Item 23e) (Type, Print) Kent Ave Suite 102 Cumberland Zaman MD

Registrates Signature

State

Registrar



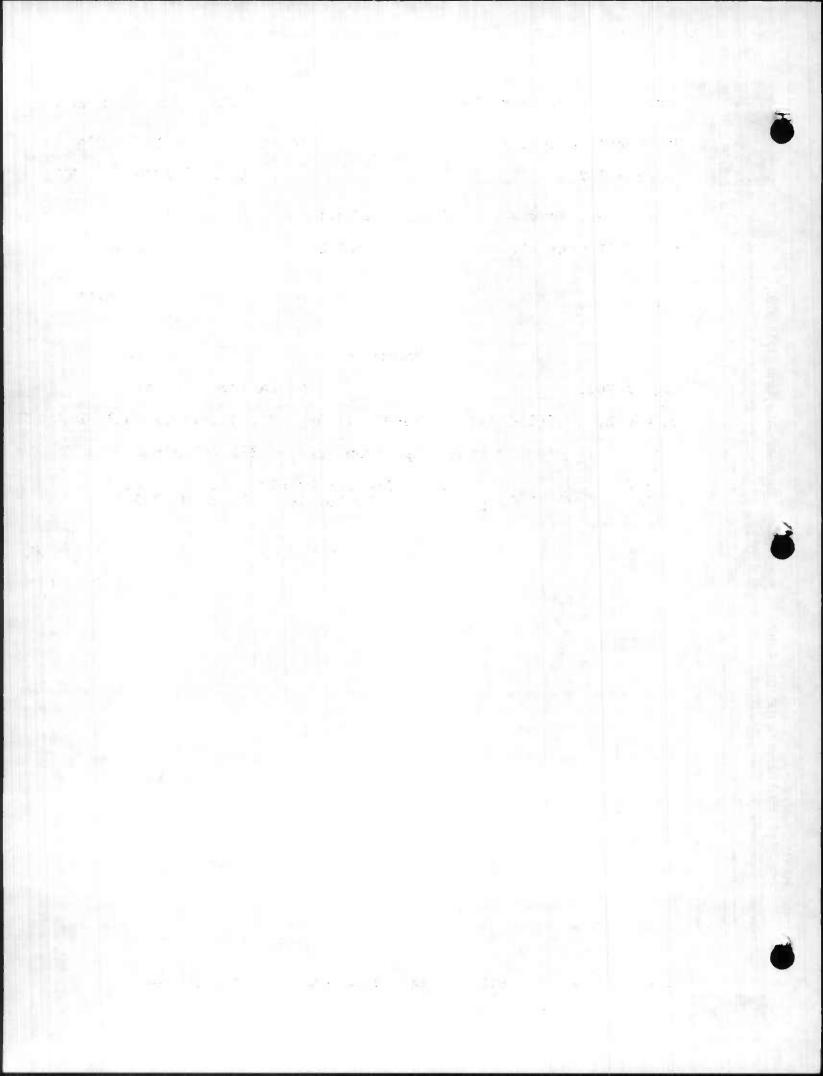
# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

1. Decedent's Nam	ne (First, Middla, La	ist)					2. Dete of	Reg. No	3. Tir	me of Death
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4e Fecility Neme (			ımber)			-	n, or Location of De			
St. Mar	M	<u> </u>	7 Age (In urs	lest hirthday)	f Under 1 Year		rdtown		Mary's	tete or Foreign
052-52-	1762		92	Yrs.			Min. Aug.	21 1906	Country)	VY.
10a. State	10b. County		10c. Ci	y, Town or Locat	ion	-			10d. Inst	de City Limits
MD	St. Ma	ry's	Ch	narlott	e Hall	11 /			1 🗆	Yes ZONo
10e. Street end Nu 7890 Ta	ll Oaks	P1.			10f. Zip Code 20622			10g. Citizen of U.S	What Country?	161
11. Marital Status		12. Was Dec	pedent Ever in U	,S. 13. Wa	s Decedent of H	lispanic Origin	? (Specify Yes or	No- 14. Rac		in,
		1 ☐ Yes If Yes, G	2 No iva			Specify:	uono moan, oto.,			
(Sne	15. Decedant's E	ducation		16a. Deceden	t's Usuei Occup d of work done	ation during most o	of working	16b. Kind of B	lusinass/Industry	
Elementary/Seco			College (1-4or 5+)			d)		7.7		
17 Father's Name	/First Middle 1 co.	1)		Homem	aker	18 Matha	Name /First Mid			
0		Type, Print)		19b. Mailing	Address (Street					
Andrew E. Seyfried/Son 7890 Tall Oaks Pl. Charlotte Hall,MD 200										
1 🗆 Buriai 2	Cremation 3		Stete Met	cometery, cremater of the composition of the compos	cov or other da Can Ca	em.				
21. Signa e o Fu	unerel Service Lica	nsee/	/ MOC							
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shock, or has	ert feilure. List only	one ceuse on	each line.	III. Do not enter i	the mode of dyn	ig, suoit as or	ildioo oi roopiiatoi	y unost,	Interva	al Between and Death
Immediate Causa	(Final	_ ^	enia	ation	P m	Celin	201110		2	large
disaase or condition resulting in death)	on	a	Duning		000 00	1	Jan 4			0,
			A.	RNC	1100 01).				2	days
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Cause (Disease or that initiated events resulting in deeth)	S	C	01-							
				or as e consequer	nca of):					
		d		or as e consequer	nca of):					
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Part II. Other eigni	L		leath but not res			ven in Part I.		old tobacco use co		ause of death?
Part II. Other eigni	L		leath but not res			ven in Part I.	1 24a. W		3 Probably  24b. Were autoevallable	4) Unknown
Part II. Other eigni	L		death but not res			ven in Part I.	24a. W	Yes 2 No	3 Probably  24b. Were autoevailable complatio	4) Unknown  Dopsy findings  prior to  n of causa
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	flicant conditions of	contributing to c		sulting in tha unde	arlying cause gi	26. Place c	24a. W pl	Yes 2 No	3 Probably  24b. Were authevallable complation of deeth?  1 Yes	4) Unknown  opsy findings  prior to  n of causa
25. Was case referexaminer?	flicant conditions of	Hospital: 1 X	Inpatient 2 Coof Injury	sulting in tha unde	arlying cause gri  3□ DOA Off  28c. Inju Wo	26. Place c	24a. W Print of Death (Check on Ing Homa 5 R 28d. Descri	□ Yes 2□ No  /as en autopsy shormed?  □ Yes 2 No //y one)	3 Probably  24b. Were autory evailable complation of deeth?  1 Yes	4) Unknown  opsy findings  prior to  n of causa
25. Was case reference a carminer?  1  Yes 2 2 27. Manner of Deel 1 Natural	rred to medical	Hospital: 1 28a. Date (Moorn Place)	Inpatient 2 □ of Injury nth, Dey Year)	DER/Outpatient 28b. Time of Injury ome, farm, streel	arlying cause gri	26. Piace oner: her: 4 □ Nurs ry et rk?	24a. W Print of Death (Check on Print Homa 5 R 28d. Descript D 28f. Location	Yes 2 No  Vas en autopsy shormed?  Yes 2 No  No  Ny one)  esidenca 6 Ott	3 Probably  24b. Were autore evailable complation of deeth?  1 Yes  her (Specify)	Dopsy findings prior to n of causa
25. Was case referexaminer?  1 Yes 2 2  7. Manner of Deel  2 Accident  3 Suicide	rred to medical  No th 5 Pending investigation 6 Could not be determined	Hospital: 1 X 28a. Date (Mo)  28e. Plac bulk  29e. Plac bulk	Inpatient 2  of Injury nth, Dey Year) a of Injury - At hing, etc. (Speci	DER/Outpatient 28b. Time of Injury ome, farm, street	arlying cause given and the state of the sta	26. Place of ner: 4 \( \to \) Nurs ry et rk? Yas 2 \( \to \) No	24a. W print of Death (Check on Sing Homa 5 🗆 R 28d. Description 28f. Location City or place, and due to the sing Homa sing Homa single singl	Yes 2 No  Vas en autopsy enformed?  Yes 2 No  Ny one) esidenca 6 Otto be how injury occu	3 Probably  24b. Were autore evaluable complation of deeth?  1 Yes  ther (Specify)  rred  there are a stated.	Doby findings prior to n of causa
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State Registrar 31. Dete filed (Month, Day, Year)
MAR 1 2 1999

32. Registrar's Signature

B. Sparks



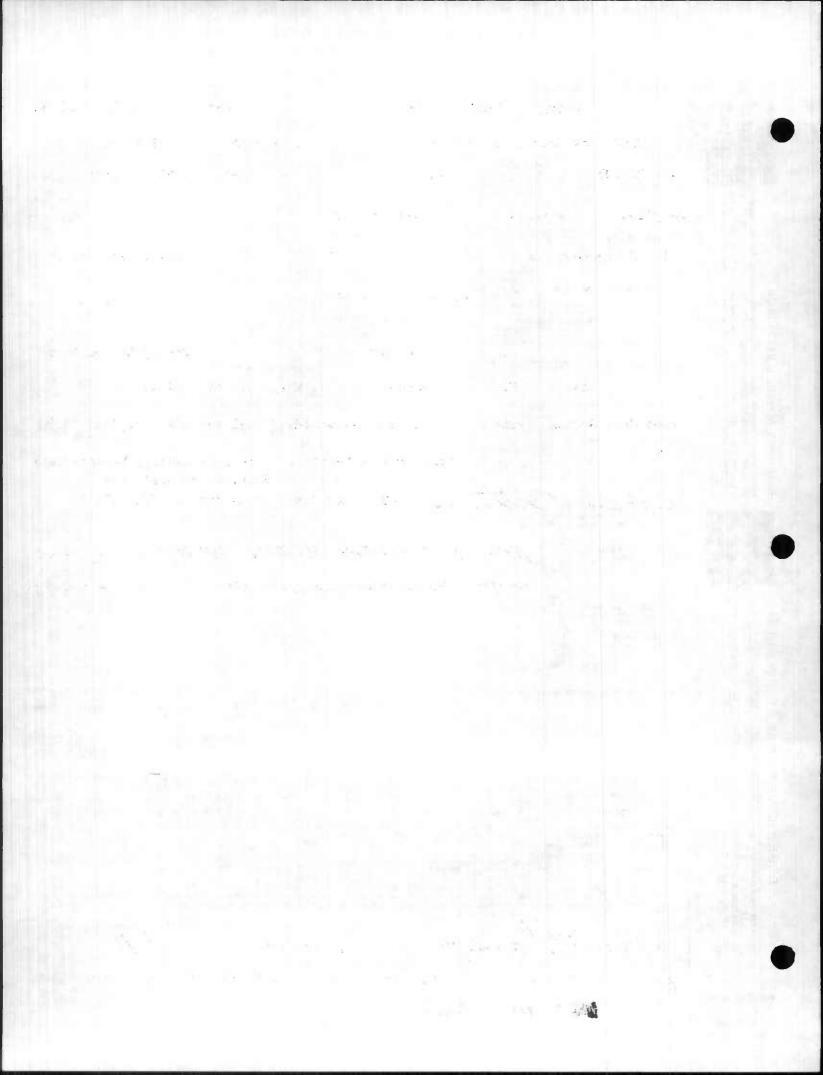
#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 8 1999 2:38 AM Mer1e Seaton March George /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey, Year) 5. Sociei Security Number 7. Age (In yrs. lest birthday) Birthpiece (State or Foreign Country) **Funeral** 100 M 2□ F Months Deys Yrs 70 196-22-1072 Director Feb. 13,1929 Pennsylvania Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at with the Maryler Maryland Frederick Walkersville 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Georgetown 21793 Road United States 2 should be filed within 72 hours after death vising Mental Hygiene.

Is marked other than \*natural', or team not Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. r-Z Yes 2 □ No If Yes, Give Yeer or Detes: 51-53 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher County School Board 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) John M. Seaton Margaret A. Miller 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) permit. Pages 1 end 2 st Department of Health end Important: if frem 27 ie in any Injury or other traun pnce. 14 Georgetown Rd ./ Walkersville, Maryland 21793 Dona Maye Seaton / wife 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 3-11-99 Dunbar, Pennsylvania Mount Auburn Cemetery 22. Name and Address of Fecility Stauffer Funeral Home 21. Signeture of Funeral Service Licensee 40 Fulton Ave. / Walkersville, Md. elerson 23e. Parti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock or heert failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** ADULT RESPIRATORY DISTRESS SYNDROME /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner MYELOGENOUS LEUKEMIA death certificate be executed attending physician and for use es the bunel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es e consequence of) Physician/Medical thet initiated events resulting in deeth) Lest Due to (or es e consequence of) 98 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 25 No 3 Probably 4 Unknown 3 Division of Vital Records. þ 8 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Wes en autopsy Deen has 212 No 1 ☐ Yes 25 No director, Be 25. Was cese referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 27 No 2 1) Inpatient 2 ER/Outpetient 3 DOA this 28e. Dete of Injury (Month, Dey Year) funeral 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Certification: After Naturel 2 ☐ Accident 5 Pending after death. 1 Yes 2 No Investigation 6 ☐ Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 0 Hospital 24 hours Tertifying Physician: To the best of my knowledge, deeth occurred et the fime, dete end piece, end due to the ceuse(s) end manner es stated.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and piece, end due to the ceuse(s) end manner stated. 29e. Certifier edical completely (Check only one) To the Within 2 29c. License number 29d. Dete signed (Month, Dey, Yeer) 29b. Signature and title of certifie 31761 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 501 W. SEVENTH ST. BHANM, O'CENNON FREDERICK MO MO 32. Registrer Signature

Registrar



Please Type or Print In Black Indelibie Ink. Assure Ali Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) Day Month Sturgis Walter **Physician** Feb 26 1999 1030 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Year If Undar 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Data of Birth (Month, Day, Year) Funeral 1₩ M 2□ F Days Hours 221-16-6577 Yrs. 71 Director Mar 13, 1927 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Worcester Directo Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 10307 Doe Drive Herris 23a 21811 U.S. Funeral 12. Was Decadent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Baca - American Indian 11. Marital Status Black, White, etc. 1 Nevar Marriad 2 Married 1 □ Yas 2 No If Yes, Giva Year or Dates: ò 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th Domestic unknown is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surnama) and Mental Robert Sturgis Eleanor Tingle 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120/99 Eunice Morris/friend Department of Health mportant: If Item 27 10307 Doe Drive, Berlin, MD 21811 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Bethel UMC Cemetery 3/6/99 Berlin, MD 21811 21. Signature of Faneral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onsat and Death Part Enter the discussion of complications that caus shock, or heart failure. List only one cause on each Physician Immediate Cause (Final disease or condition resulting in death) /Medical Carcinoma Examiner Examiner percalcemia physician and s the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that Initiated events resulting in death) Lest Physician/Medical Due to (or as a consequenca of): Walter Sturgs 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. the Probably 4 Unknown signed by 1 Yes 2 No þ 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? Completed complation of cause of deeth? hes 1 Yes 2 No this certificate ! 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examiner? Be 28. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Danpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? After 5 Pending investigation 1 Yes 2 No 2 Accident 24 hours after daat Funeral Director: 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decritiying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 29e. Certifier edical (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner steled. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tale of cartifier gradula in 028769 1209 OCEAN HIGHWAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NI CHOLAS N BOROULIA, WWD Island, De Famulck

32. Degistrar's Signature

DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Day, Year)

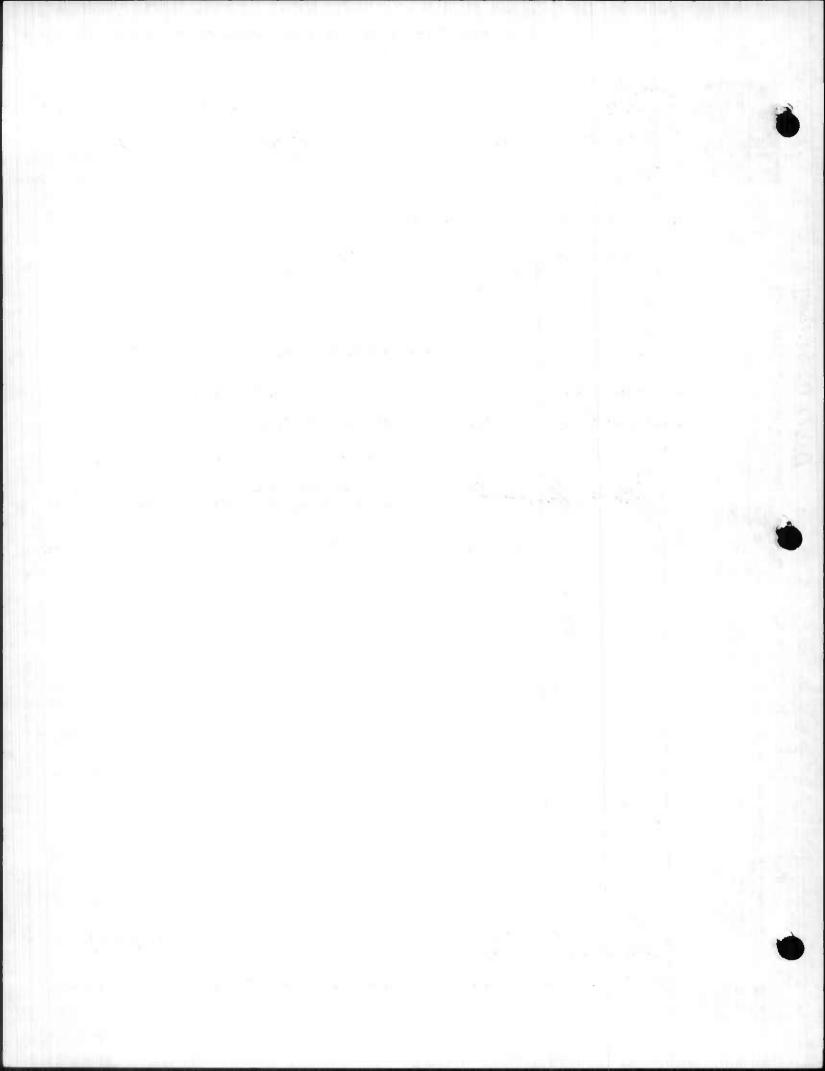
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Division of Vital Records,	Attending Physician: The law requiras that the death cer ricesth. sctor: After this certificate has been signed by the ettendin by the funeral director, page 2 should be detached for use	Completed by										periormed? av		autopsy findings ble prior to ation of causa h?	
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the Maryland

Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiena. int: if Item 27 is merked other than \*r other t any Injury or Department Important: If

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**Physician** /Medical Examiner

certificate be axecuted ician and burial-trans physician the 88 950 168 page 2 certificate funeral director, this

P.O. Box 68760 Division of Vital Records, Hospital or Attanding Physician: 24 hours after death.

Funeral Director: Af To the Hospital or within 24 hours aft To the Funeral Di completely filled in

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month CLYDE SMITH 07 99 1:48 PM March 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Wicomico Nursing Home Salisbury Wicomico 8. Date of Birth (Month, Dey, Year) 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months Days Hours Min. Yes 87 217-10-3572 NOV. 6,1911 VIRGINIA Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 805A COLLEGE LANE 21804 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Maritel Stetus Bleck, White, etc. 1 □ Never Married 2 X Married 1 ☐ Yes 2 No Specify p 3 Widowed 4 Divorced WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) BUS DRIVER CAROLINA COAH 12 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) J. **EDGAR** SMITH BERTHA AMES 10 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MADELYN L. SMITH - WIFE 805A COLLEGE LANE SALISBURY, MARYLAND 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARDELA MEMORIAL CEMETERY 3-11-99 MARDELA SPRINGS, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility 705 E. MAIN ST. 21804 Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. SALISBURY, MD Approximate Interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Examiner INSULIN DEPENDENT DIABETES MELLITUS YRS Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequenca of). Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopay findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4K Nursing Home 5 Residence 6 Other (Specify) 2 1□ Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Netural 2 Accident 5 Pending investigation 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and menner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of cartifier

5302 Chinaberry Dr., Salisbury, MD 21801

State Registrar negario

31. Date filed (Month, Day, Year)

Gregoria M. Belloso,

MAR 0 9 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

FEE S U BVW

Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Swartz March 6, 1999 5:15 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Center: Genesis ElderCare Salisbury, Wicomico MD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□M 21 F Months Hours Min Yrs. Director 84 June 24, 1914 326-18-9319 Mississippi 10a State 10b Counts 10c. City. Town or Location 10d. Inside City Limits ty Yes 2 □ No Maryland Wicomico Director Salisbury 288-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 200 Civic Ave. Berns 23s 21804 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Rece - American Indien. 11 Meritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify White p 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Domestic 12 Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental George Washington Payne Ella Etheridge 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Swartz Sr./ Son important: If Ibam 27 any injury or other to 315 Decatur Ave., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel Irom State 3/9/99 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial Park 22. Name and Address of Fecility 21. Signature of Funerel Se M01051 Holloway Funeral Home Professional Association 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hearf failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) ceabor Examiner Physician/Medical Examiner ician and burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (er as a consequence of) physician the burial Box 68760, Due to (or as a consequence of): for use signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1□ Yes 2E-No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division or Attending 1 Pretural 5 Pending investigation 1 Yes 2 No r death. 2 Accident 24 hours after deat Puneral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier completely (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

WilliAM

31. Date filed (Month, Day, Year)

1104

32. Registrar's Signature

HEAlthWA

SALISBURY

21804

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

Robbins

MAR 1 0 1999

S. L. S. F. S. ELEPAN

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 09322

December   Controlled   December   Controlled   December   Controlled   December   Dec						Cei	rtificat	te of	Death		1	Reg. No.			
DOTO THE A J. STITCH  FAMILIAN  FOR STATE A CHIEF M. STATE CREEK  ANNAPOLIS  Solid Sharesy Patients of a continuous of Same and Annihold  FOR STATE STATE CREEK  ANNAPOLIS  ANNA			1. Decedent's Nama (First, Middla, Last)											3. Time of Death	
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CENESTS ELDER CARE SPA CREEK  ANNAPOLIS  1.0 M QV   10 M	- C		4a Fecility Name (If not institution,	giva street and num	ber)				4b. City, To	wn, or Locatio	n of Death	1			
The control of the			GENESIS ELDER CA	RE SPA	CREEK							ANNE	ARUN	DEL	
The State of Control o	Fune	eral	5. Social Security Number							24 Hrs. 8. [	ete of Birt Wonth, Day	h y, Year)	9. Birthi	place (Stata or Foreign intry)	
JOHN GEORGE  JOHN M. TAYLOR FUNERAL HOME, INC  GEORGE GEORGE  JOHN M. TAYLOR FUNERAL HOME, INC  JOHN M. TAYLOR FUNERAL		ctor	136 54 6658 JUNE 07, 1905 NEW										JERSEY		
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Physician //Idealian /	Separation of the separation o	ny le	21. Signature of Funeral Service Li	OHITSON /	6	) <sup>2</sup>	2. Name a	na Adar	ess of Facili		M. TA	YLOR FL	JNERA	L HOME, INC	
Physician Medical Examinor  Physician  Physician Medical Examinor  Physician  Physician Medical Examinor  Physician  Physician  Physician Medical Examinor  Physician  Phy	- 605	<b>a</b> a	Malest.	Lu	4	14	47 DU	KE C	F GLO	UCESTE	R ST.	ANNAPO			
Physician Medical Examiner    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23a. Part1. Enter tha disease, or c shock, or heart failure. List or	omplications that ca nly one cause on aa	usad tha daath. D ch lina.	o not en	tar the mo	de of dy	ing, such as	cardiac or res	piratory a	rast,	- 1	Approximata Intarval Batween	
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Cause (Disease or Injury Institutional devents are utiling in death) Last  Due to (or es e consequence of):	2 1	line		b	HYPE	RTE	ENSIG	N							
Cause (Disease or Injury Institutional devents are utiling in death) Last  Due to (or es e consequence of):	Bocut	-trar	Sequentially list conditions, if any, leading to immediate		Due to (or as	a consec	quence of)	:							
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30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)  ROBERT SCOTT EDEN, M.D., 600 RIDGELY AVE, ANNAPOLIS, MD 21401  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	Hos 24 ho	dica	(Check only 2 Medical E	caminer: On the bas	is of examination										
30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)  ROBERT SCOTT EDEN, M.D., 600 RIDGELY AVE, ANNAPOLIS, MD 21401  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	thin the	M M	29b. Signatura end titla of certifier	0			29	c. Licen	se number			29d. Date sign	ed (Month	, Day, Year)	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3 Time of Deeth SAVOY 2328 1/1/ AM MAR 4e. Fegility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death tun 100113 rundel NNE Sociel Security Number 6. Sex if Under If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) 8. Dete of Birth (Month, Dev. Year) Months Hours 214-05-1789 85 3 1913 MARYLAND NOV. Usuei Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND ANNE ARUNDEL ANNAPOLIS 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f Zip Code 10g. Citizen of What Country? 210 B. APT. 106 HILL TOP LANE 21403 US 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No tf Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American indien. Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No f Yes, Give Year or Detes: 3 Widowed 4 Divorced BLACK 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 1st. TRUCK DRIVER JOHNSON LUMBER CO. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) WILLIAM I. SAVOY EMMA SOMERVILLE 19e. tntorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MARY LAWRENCE (DAUGHTER) P.O. BOX 162 PRESTON, MD. 21655 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) ANNAPOLIS MEM. GARDENS 3/15/99 ANNAPOLIS, MD. 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility WM. REESE & SONS MORTUARY, P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart feilure. List only one cause on each line.

821 WEST ST ANNAPOLIS, MD 21401
Approximate Intervel Between Onset and Deeth piratory Failure immediate Cause (Final diseese or condition resulting in death) ENTERI Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence ot): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Nunknown 1 ☐ Yes 2 ☐ No 24e. Wes en eutopsy performed? 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1 Yes 2 3 No 1 ☐ Yes 2 ☐ No

**Physician** /Medicai Examiner

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Attending Physician:

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death.

To the Hospital within 24 hours a To the Funerel D

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The law requires that the death cartificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

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**Funeral** 

Director

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Examiner munt be notified at

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Baltimore, Maryland

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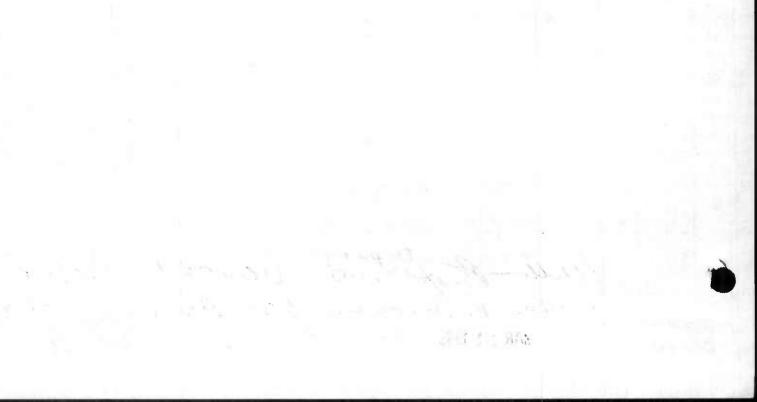
Examiner Physician/Medicai the for usa as þ 90 page 2 should Completed director, Be 10 funeral Certification: filled in by the

Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 25. Wes case reterred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XXes 2 No 1 Nnpatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 17 Neturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Sulcide 6 Could not be 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physictan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner steted. 29a. Certifier (Check only one) 29b. Signetare end title of certitier 29c. License number Deputy 29d. Dete signed (Month, Dey, Year)

State Registrar 31. Dete tiled (Month, Dey, Year) 32. Registrer's Signeture

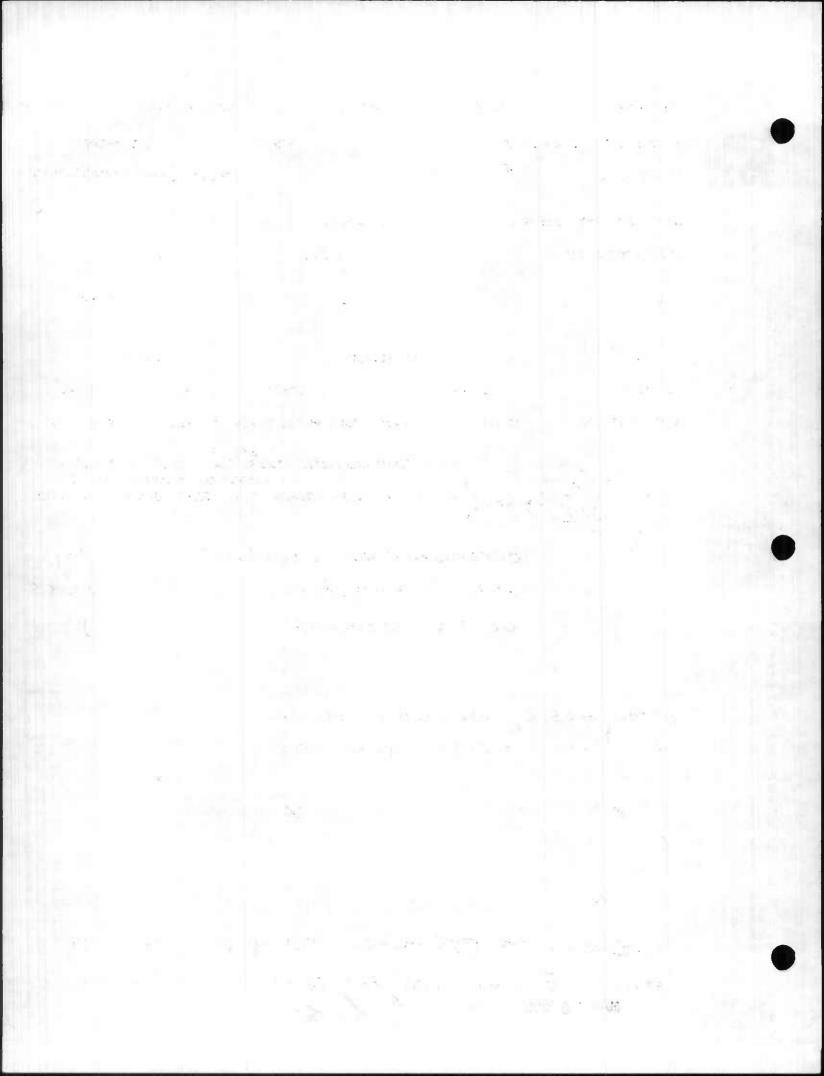
ne end eddress of person who completed sause of deeth (Item 23a) (Type, Print)



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			State of M	aryland /	Department of Certificate or			JIENE* Reg. No.		
		1. Decedent's Nama (First, Middle, L.	ast)				2. Dete of Dea	ith		3. Time oi Death
Physicia	_	PHYLLIS	JANE		STULL		Month MARCH 7	7, 1999	Year	12:50 AM
/Medic Examin		4a Facility Nama (If not institution, gi	ve street and number)			4b. City, Town, or Location of De				
Examin	er	FUTURE CARE AT CH				ARNOLD		ANINI	2 Apr	INDEL
Funeral				ge (In yrs. last i	pirthday) If Under 1 Yes	If Undar 24 Hrs.	A Date of Birth	1		place (State or Foreign
Director		160-20-8427  Usual Residence of Dacedant  1							PENN	ISYLVANIA
the Maryland 28a-f show notified at		10a. Stata 10b. County		10c. City, To	wn or Location				1	Od. Inside City Limits
ith with the Marylar 23a or 28a-f show ust be notified at	Ö	MARYLAND ANNE AF	RUNDEL		GLEN BURNI	E				1 ☐ Yes 2 🕱 No
the the	9	10e. Street and Number		1	10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
ith with 23e or		106 DICKENS STREE	ET		210	061		U.S.A.		
death with ms 23s or	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U,S.	13. Was Decedent of	Hispenic Origin? (Spuban, Maxican, Puarto	ecify Yes or No-	14. Race		can Indian,
	F	1 Never Merried 2 Married	Armed Forces?	No			Rican, etc.)	Blac	k, Whita,	etc.
5-0020 72 hours after neturel; or its	by	3X Widowed 4 □ Divorcad	If Yes, Give Yaar or Dates:		1 ☐ Yes 2√ N	o Specify:		Specify	WHI	TE
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s man		19a. Informent's Name/Relationship	(Type, Print)	1	9b. Mailing Addrass (Stra	at and Number or Rui	rai Route Numbe	r, City or Town,	State, Zip	Code)
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other t		20a. Method of Disposition		20b. Place	of Disposition (Name of tery, crematory or other p	lagal	Data	20c. Location -		
TO Pend of the Pen		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special				3	/10/99	GUECMER		DUI NID
三 一	-	21. Signature of Funeral Service Line	igsee 2	CRESA	PEAKE CREMA! 22. Name and Add	ITON CENTE		CHESTER		
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r Vita	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Magner of Death	Hospital: 1   Inpati	ent 2 ER/	Outpatient 3 DOA	26. Place of Dea	th (Check only of ome 5 - Resident	rmad? (es 2 No	oi 1	vallabla prior to omplation of causa death?
On of Vita	To Be	25. Was case referred to medical examiner?  1  Yes  No  27. Magner of Death 1 Natural 5 Panding investigation	Hospital: 1 Inpati	ent 2 ER/	Outpatient 3 DOA Co. Time of Injury	26. Place of Dea	th (Check only of ome 5 - Resident	rmed? (es 2 No ne) denca 6 □Oth	oi 1	vallable prior to omplation of causa death?
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On of Vita	To Be	25. Was case referred to medical examiner?  1  Yes  No  27. Magner of Death Natural 5  Panding investigatic 3  Suicide 6  Could not death	Hospital: 1   Inpati	ent 2 ER/	Outpatient 3 DOA  Time of Injury  M  1	26. Place of Dea Other: 4 Nursing H jury at lork? □ Yes 2 □ No	th (Check only of ome 5 - Residue) 28d. Describe h	mad?  Ves 2 No  ne)  denca 6 □Oth  now Injury occur  Street and Numb	1 1 ser (Speciated	vallable prior to mplation of causa death?  Yes 2 No
On of Vita	To Be	25. Was case referred to medical examiner?  1 Yes No  27. Magner of Death Natural 5 Panding investigatic 3 Suicide 4 Homicide 6 Could not datermined	Hospital: 1 Inpati 28a. Date of Injuiding. el 28e. Place of Inbuilding. el hysicien: To the best	ent 2 ER/ July Year) 281 jury - At homa. ic. (Specify) of my knowled if examination	Outpatient 3 DOA  Time of Injury  M  1	26. Place of Dea  Other:  Vork?  Yes 2 No	th (Check only of ome 5 Residence 28d. Describe has been due to the end due to the	rmad?  (es 2 No  ne)  Jenca 6 Oth  now injury occur  Street and Numb  m, State)	1 1 er (Speciared	vallable prior to mplation of causa death?  Yes 2 No
On of Vita	Be	25. Was case referred to medical examiner?  1  Yes No  27. Magner of Death 1  Natural 5  Panding investigation of Could not 1 datermined  2  Accident 4 Homicide  Could not 1 datermined	Hospital: 1 Inpati 28a. Date of Inju (Month, Date) 28a. Place of Intuiting, etc.	ent 2 ER/ July Year) 281 jury - At homa. ic. (Specify) of my knowled if examination	Outpatient 3 DOA  Time of Injury M 1  Iarm, street, factory, office ge, deeth occurred et the and/or investigation, in more	26. Place of Dea  Other:  Vork?  Yes 2 No	th (Check only of ome 5 - Residence 28d. Describe has been as a constant of the constant of th	rmad?  (es 2 No  ne)  Jenca 6 Oth  now injury occur  Street and Numb  m, State)	of 1  ler (Speciared  per or Run  spinar as and due to	vallable prior to mplation of causa death?  Yes 2 No
of Vita hysician: his certifical al director	edical Certification: To Be	25. Was case referred to medical examiner?  1	Hospital: 1 Inpati 28a. Date of Injuiding. el 28e. Place of Inbuilding. el hysicien: To the best	ent 2 ER/ July Year) 281 jury - At homa. ic. (Specify) of my knowled if examination	Outpatient 3 DOA  Time of Injury M 1  Iarm, street, factory, office ge, deeth occurred et the and/or investigation, in more	26. Place of Dea Other:  When the second sec	th (Check only of ome 5 - Residence 28d. Describe has been as a constant of the constant of th	rmad?  (es 2) No  (ne)  denca 6 □ Oth  now injury occur  Street and Numb  m, State)  cause(s) and madata and placa,	of 1  ler (Speciared  per or Run  spinar as and due to	vallable prior to mplation of causa death?  Yes 2 No

State Registrar



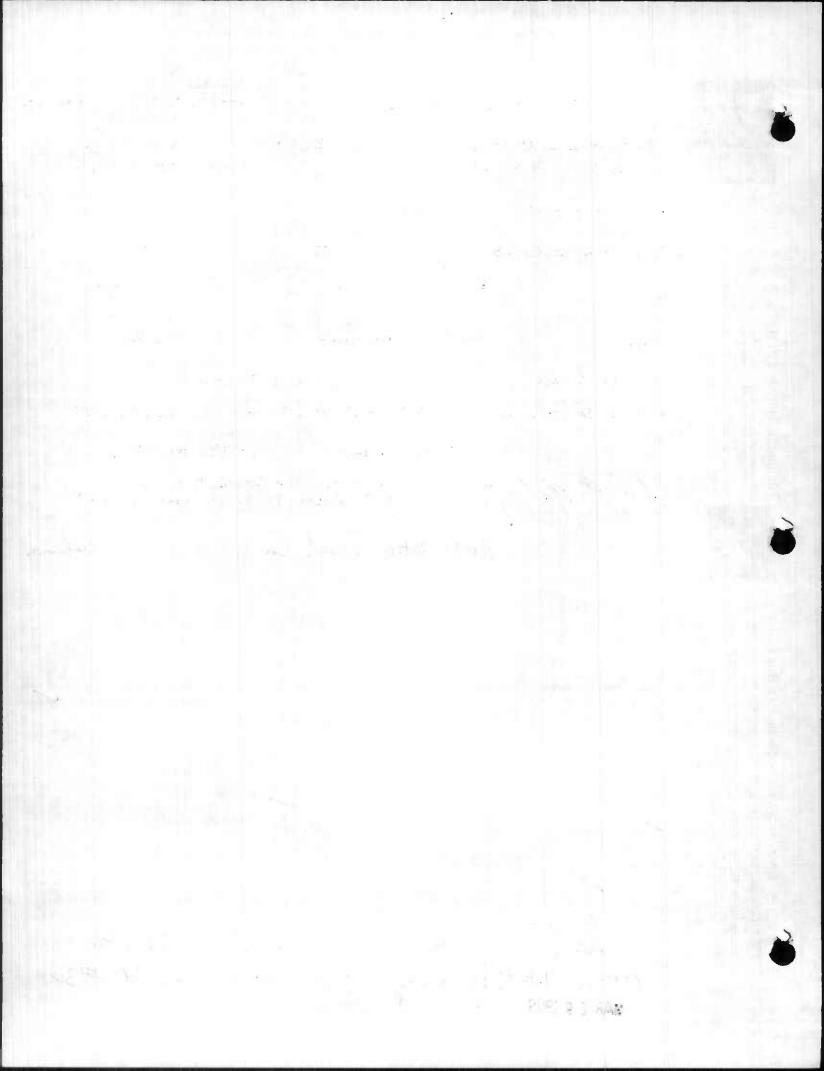
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3. Tima of Death March 8, **Physician** 6:00 A.M. Edna Saunders Mary /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva straat and number) Examiner Millenium at South River Edgewater Anne Arundel Birthpiace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year)
April 16,1910

9. Birthplace (Ste If Undar 1 Yaar 7. Aga (In yrs. last birthday) **Funeral** Hours Min. Days 1 M ADF Months Yrs. 223-98-7286 88 Director Usuel Residence of Dacedant the Marylend 10a, Stata 10c. City. Town or Location 10d. Insida City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland Anne Arundel Edgewater 1 Yas 2 No Director 10e. Street and Number 10f. Zin Coda 10g, Citizen of What Country? with 3573 South River Terrace 21037 USA pemit. Peges 1 and 2 should be filed within 72 hours after death Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 234 any injury or other traumatic event, ma Medical Eram he must once. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2021No If Yas, Giva 14. Race - Amaricen Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 Nevar Married 2 Married Specify: White 1 ☐ Yas 2 No Spacify: altimore, Maryland 21215-0020 Aq. 3 Nidowed 4 □ Divorced Yaar or Datas: 16a. Decedant's Usual Occupation
(Giva kind of work done during most of working
life. DO NOT use ratired)
Homemaker Completed 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/industry Collaga (1-4or 5+) Elemantery/Secondary (0-12) 7th At Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Neme (First, Middla, Maiden Sumama) James Edgar Newsome Annie Frank Jones 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) 19a. Informant's Name/Raiationship (Type, Print) 3573 South River Terrace Edgewater, MD. 21037 Franklin N. Saunders/Son 20b. Piace of Disposition (Nema of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 3/10/99 Reedville.VA. Roseland Cemetery 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility George P. Kalas Funeral Home, P.A. 49 2973 Solomons Island Rd. Edgewater, MD21037 int paused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest or each line. **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in daath) Examiner Examiner physician end s the buriel-transit requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Diseasa or Injury that initiated evants rasulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Dua to (or as a consequance of): 98 ettending 9SD 0 the t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Onknown á signed t by 24b. Wara autopsy findings availabla prior to complation of cause of daath? 24e. Wes en eutopsy Completed peed has page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate Attending Physician: 25. Wes casa refarrad to medice Be 26. Plece of Daath (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No 2 this 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Menger of Deeth 28b. Tima of 28d. Dascribe how injury occurred Certification: After o Hospital or Atternative 24 hours effer death. 1 Natural 5 Pending Invastigation 1 Yes 2 No 2 Accidant 6 Could not be detarmined 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar edical within 2 To the 29d. Data signad (Month, Day, Year) 29c. Licansa number 29b. Signatura and titla. 0 30. Name and, of daeth (Item 23e) (Type, Print) Greene Tree Rd 31. Data filed (Month, Day, Year) State MAR 0 9 1999 Registrar



### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month March 3 1999 **Physician** 3:58pm Stuhrman Jerry /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Arnold Futurecare If Under 1 Year If Under 24 Hrs. 8. Dele of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys 1 M 2 F 490-44-8303 85 Yrs. **Director** 4/4/1913 Missouri Usuel Residence of Decedent the Marylend 10e. Stete 10b. Count 10c. City, Town or Location 10d. inside City Limits rai', or items 23a or 28a-f show Examiner must be notined at 1 Yes 2 No Anne Arundel Arnold Directo MD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with USA 21012 permit. Pages 1 and 2 should be filed within 72 hours after death v. Dependment of Health and Mantal Hygiene. Important: if item 27 is marked other than "natural", or itema 23e any injury or other traumatic event, the Mantal 1350 Argyll Drive Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 to Yes, 2 □ No WWII If Yes, Give Year or Detes: Korea Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Maritel Status Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2√ No Specify: Specify: White g 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Military 2 Army Lt Col. 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Louise Eichoff John H. Stuhrman, III 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1350 Argyll Drive Arnold MD 21012 Irene Stuhrman / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slale 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 3/4/99 CatonsvilleMD 4 Donetion 5 Other (Specify) Metro Crematory 21. Signature of Emeral Separe Lio 22. Name end Address of Fecility Barranco & Sons PA Severna Park FH 23a Part. Enter the discrete, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, 21146 Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) wrong integ disease **Examiner** Due to (or es e consequence of): Physician/Medical Examine ettending physician end for use es the buriel-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or InJury that initieted events resulting In death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): ed by the deteched Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? signed by t d be detech 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown þ 24b. Were autopsy findings eveilable prior to should Completed 24e. Wes en eutopsy performed? completion of cause of deeth? ate hes t 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician; director. 25. Was cese referred to medical exeminer? Be 26. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28h Time of 28c. Injury et Work? Certification: After Nature 5 Pending 1 Tyes 2 No death. Investigetion 2 Accident within 24 hours efter death To the Funeral Director: , completely filled in by the 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - Al home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier Medical (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 90 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)
Victor Plavner, M.D., 1509 Gov. Ritchie Hwy., Arnold, MD 32. Revistrer's Signature 31. Dele filed (Month, Day, Year) State MAR 0 8 1999

Registrar

**DHMH 16 Rev 6/95** 



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1 Decedant's Name (First Middle Last) 2. Data of Death 3. Time of Death Month **Physician** 230 AM 99 ANTHONY SZCZEPANIK. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number Examiner Arunde Hrundel Medical Huna Ann If Undar 24 Hrs. Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Aga (In vrs. last birthday) **Funeral** Hours 212-26-7295 XXM 2DF Months Days 68 MAY 15, 1930 MARYLAND Director Usuat Residence of Decedent the Maryland 10d. inside City Limits x 28a-f show 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director ANNE ARUNDEL MARYLAND PASADENA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be 104 HASTINGS LANE 21122 II.S.A. a death Was Decedent of Hispanic Origin? (Specify Yes or Noit Yas, specify Cuban, Mexican, Puerto Rican, etc.) Funer Race - American Indian, Black, White, etc. 12. Was Decadent Ever in U,S. Armed Forces?

1 XYes 2 No 194
If Yes, Give 196 11. Marltai Status Pages 1 and 2 should be filed within 72 hours after on the first that that Mental Hygiene. 1 Never Married 2 Married 1947 1 ☐ Yes X2 ☐ No Specify: Specify: WHITE by 3 Widowed 4 Divorcad 1968 Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 AIR POLICE MILITARY 17 Fathar's Nama (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be **JOHN** A. SZCZEPANIK, SR. VIRGINIA MINKCHI 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) N) 104 HASTINGS LANE, PASADENA, MARYLAND 21122

20b. Placa of Disposition (Neme of cemetery, crematory or other place)

Date 20c. Location - City or Town, State or other to RICHARD A. SZCZEPANIK (SON) 20e. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from Stata Department of Important: If 4 Donation Other (Specify) STANISLAUS CEMETERY 3/8/99 BALTIMORE, MD. 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 21. Signature of 60 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 er complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, that only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Cardiopulminary disease or condition resulting in death) Examiner Examiner my o cardial physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last death certificate be execu Due to (or as a consequence of): Levere under Physician/Medical attending pl signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Whiknown 1 Yee 2 No by 24b. Were autopsy tindings available prior to completion of causa ot death? 24a. Was an autopsy performed? Completed page 2 has 2 No 1 Yes 20 No 1 Yes certificate or Attending Physician: director. Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA 2 this funeral 28c. Injury at Work? 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how Injury occurred Certification: After 1 Natural 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, tarm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 4 Homicide filled in • Funeral I Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the ceuse(s) and manner as stated. Medical completely 2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and mannar stated. (Check only one)

State Registrar 29b. Signatura and title of certified

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Data signed (Month, Dey, Year)

To the Vithin 2

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Division of Vital Records,

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day Elisabeth Miller Taylor March 6, 1999

3. Time of Death

10:07 AM

/Medical Examiner

**Physician** 

**Funeral** Director

the Maryland 10a. Stata ? Is marked other than "natural", or items 23s or 28s-f show traumstic event, the Madical Experience, must be notified at Director 10a. Street and Number Funeral 11. Marital Status 72 hours after Baltimore, Maryland 21215-0020 þ permit. Peges 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: if item 27 is marked other tran "natural", any injury or other traumatic event, the Medical Exa ponce. Completed Be 20a. Mathod of Disposition pames **Physician** /Medical Immediata Causa (Final disease or condition rasulting in death) Examiner Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last pue physician the burial Box 68760 Physician/Medical Division of Vital Records, P.O. 2 signed t P Completed peen page 2 hes certificate after deeth.

Director: After this certifications Be To 1 Yes 2 No 27. Manner of Death Certification: 1 Natural 2 ☐ Accident 3 ☐ Suicida To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier Medical

4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 125 Greenhill Road Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Ye Birthplaca (Stata or Foreign Country) Days Months Hours 1 M 28 F 230-42-2734 73 May 1, Virginia Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ₩ No Prince George's Greenbelt 10f. Zip Code 10g. Citizen of What Country? 125 Greenhill Road 20770 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, Black, Whita, atc 1 Yas 2 No
If Yes, Give
Year or Dates: 1 Nevar Married 2 Married White 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Father's Name (First, Middle, Last) Isaac Franklin Miller Bessie Virginia Jones 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jack C. Taylor/Husband 125 Greenhill Rd., Greenbelt, MD 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/8/99 Alexandria, VA Metropolitan Crematory 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., West Silver Spring, MD 20901 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that (a) at the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ne. Approximata Interval Between Onset and Death Metastatic Bronchogenic Carcinoma Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacço use contribute to the cause of death? 11 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical axaminer? 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Pending invastigation 1 Tyes 2 No 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, etreet, factory, office building, etc. (Specify) 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only one) 29b. Signatura and titla of certifier 29c. License number 29d. Data signad (Month, Day, Year) 039550 3-8-99 en C. 30. Name and addrass of person who completed ceuse of death (item 23a) (Type, Print) 4850 Forbes Blud Lanham, Mrd 20706 George C. Majjar . Jr. m.o.

**DHMH 16 Rev 6/95** 

State

Registrar

31. Date filed (Month, Day, Year)

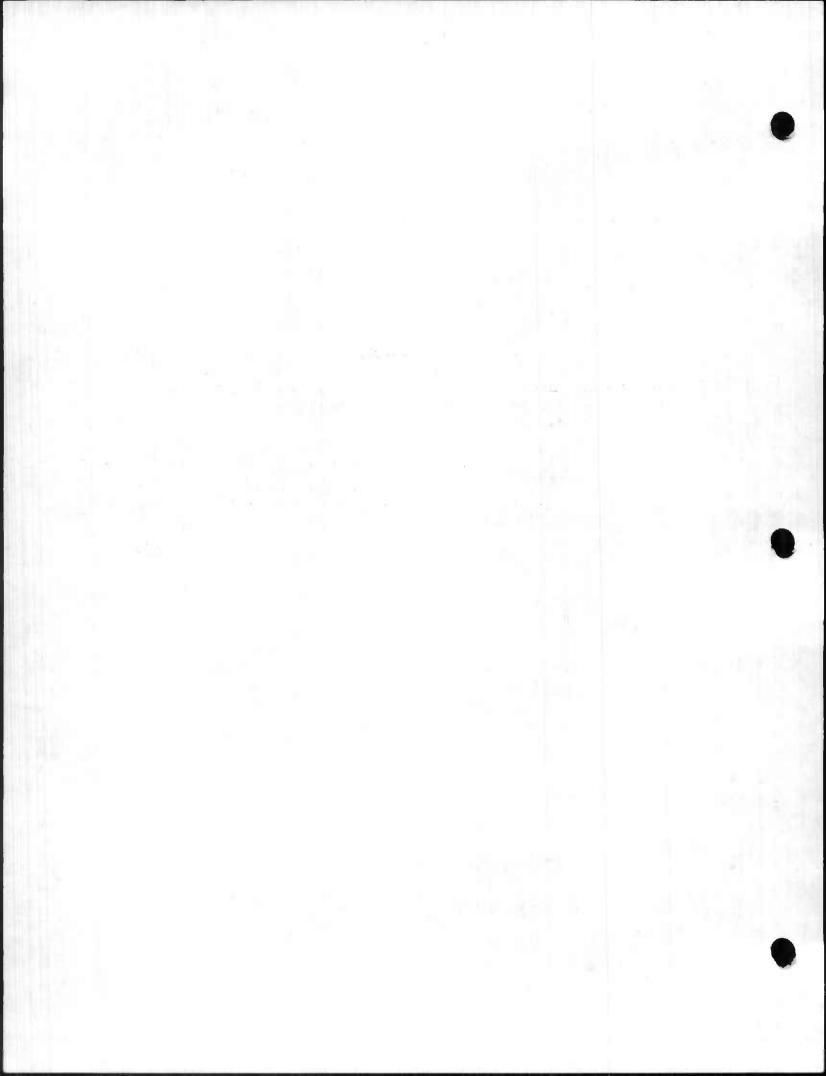
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32. Registrar's Signature

Masera



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AYLOR ITEMS: #23	B PART I, 27 PER MEO		-						ierie	U.	206.
Physician /Medical	1. Decedent's Nama (First, Middle, Zoie Claudia			73				2. Date of Death Month MARCH	Day	Year	3. Time of Death 0553 AM
Examiner	4a Facility Name (If not institution, PRINCE GEORGES			?			own, or L VERLY	ocation of Death	4c. County PRIN		EORGES
Funeral Director	217-53-7699	i. Sex 1 ☐ M 2 ☐ X F	7. Age (In yrs.	last birthday) Yrs.	if Under 1 Ye Months Da 3 2	ys Hours	Min.	8. Date of Birth (Month, Dey, Nov. 12			place (State or Foreign htry)
cured above	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince	e George		y, Town or Lo	ocation					•	10d. Inside City Limits 1 ☐ Yes ※XNo
23e or 28 al Direc	10e. Street and Number 75 Harry S. Trus	man Driv	e, Apt.	24	10f. Zip Cod				og. Citizen of United		
netural, or items 23s or 28s-f show ideal Examiner must be notified at leted by Funeral Director	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Fo	2 XNo ve		Was Decedent If Yas, specify C			pecify Yes or No- p Rican, etc.)		ck, White,	can Indian, etc. ack
n "natural fedical i	15. Decedent's (Specify only highest			(Give	dent's Usual Oc kind of work do DO NOT use re	ne during mo	st of work	king	16b. Kind of B	usiness/In	dustry

10a. State Funeral Director Maryland 10e. Street and Number 75 Harry S. 11. Marital Status To Be Completed by

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Meryland Department of Haaith and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, in Medical Examine Fruit be notified anone.

Paltimore, Maryland 21215-0020

Physician /Medical **Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completaly filled in by the funeral director, page 2 should be datached for use as the bunal-transit Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

0	Conogo (1 401 01)	None				None		
17. Father's Name (First, Middle, Last)		,		18. Mother's I	Name (First, Middle	, Maiden Sumen	na)	
Ronald G. Taylor				Kimber	cly Denic	e Munson	1	
19a. Informant's Name/Relationship (T	ype, Print) (parents	19b. Mailing Addr	ress (Street	end Number or	Rurel Route Numb	er, City or Town,	State, Zip Code)	
Ronald & Kimberly			y S. T	ruman I	Drive, #2	4, Largo	, MD 20	774
20a. Method of Disposition		Place of Disposition (	(Name of	(a)	Date	20c. Location	City or Town, Sta	te
1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donetion 5 ☐ Other (Specify,	Removal from State	hesapeake			3-12-99	Beltsvi	lle, Mar	yland
21. Signature of Funeral Sarvice Licens	aa O	Rapp		al Serv	vices, P. Silver S		(aryland	20910
23a. Part1. Enter the diseese, or comp shock, or heart failure. List only of	lications that ceused the deat ne ceuse on each line.						Approx	and the same of th
Immediate Ceuse (Finel disease or condition	SUDD	EN INFANT DE	EATH SY	NDROME				
resulting in death)	Dua to (d	or as a consequence	of):					
	h							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	Due to (c	or as a consequence	of):	44				
that initiated events resulting in death) Last	Dua to (o	r as a consequence	of):			L F		
	d							
Part II. Other significant conditiona co	ntributing to death but not res	ulting in the underlying	ng cause giv	en in Part i.	23b. Dld	tobacco use co	ontribute to the ca	use of death
					1	Yee 2□ No	3 Probably	4 Unknow
						s en eutopsy omed?	24b. Were euto available p completio of death?	psy findings prior to n of cause
25. Was cese referred to medicel				26. Place of I	Death (Check only	one)		
examiner? 1 ☐ Yas 2 ☐ No	Hospital: 1 ☐ Inpatient	ŒR/Outpatient 3□	DOA Oth	er: 4 Nursin	g Home 5 ☐ Res	idence 6 □Oth	ner (Specify)	
27. Menner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor 1 🗆	y at k? Yes 2 □ No	28d. Describe	how injury occur	rred	
3 Suicide 6 Could not be determined	28e. Place of Injury - At his building, etc. (Specif	ome, farm, street, fac	ctory, office		28f. Location City or To	(Street and Numi wn, State)	ber or Rural Route	Number,
29a. Certifier (Check only one) 1 ☐ Certifying Phy	atclan: To the best of my kno ner: On the basis of examina and manner steted.	wiedge, deeth occurr tion and/or investige	red at the tin tion, in my o	ne, dete end pl pinlon, death o	ace, and due to the courred at the time	ceuse(s) end m date end place,	enner es steted. end due to the ce	use(s)
29b. Signatura and title of certifier	- 40 5		29c. Licens	e number		29d. Date signe MARCH	od (Month, Day, Ye	par)

State Registrar

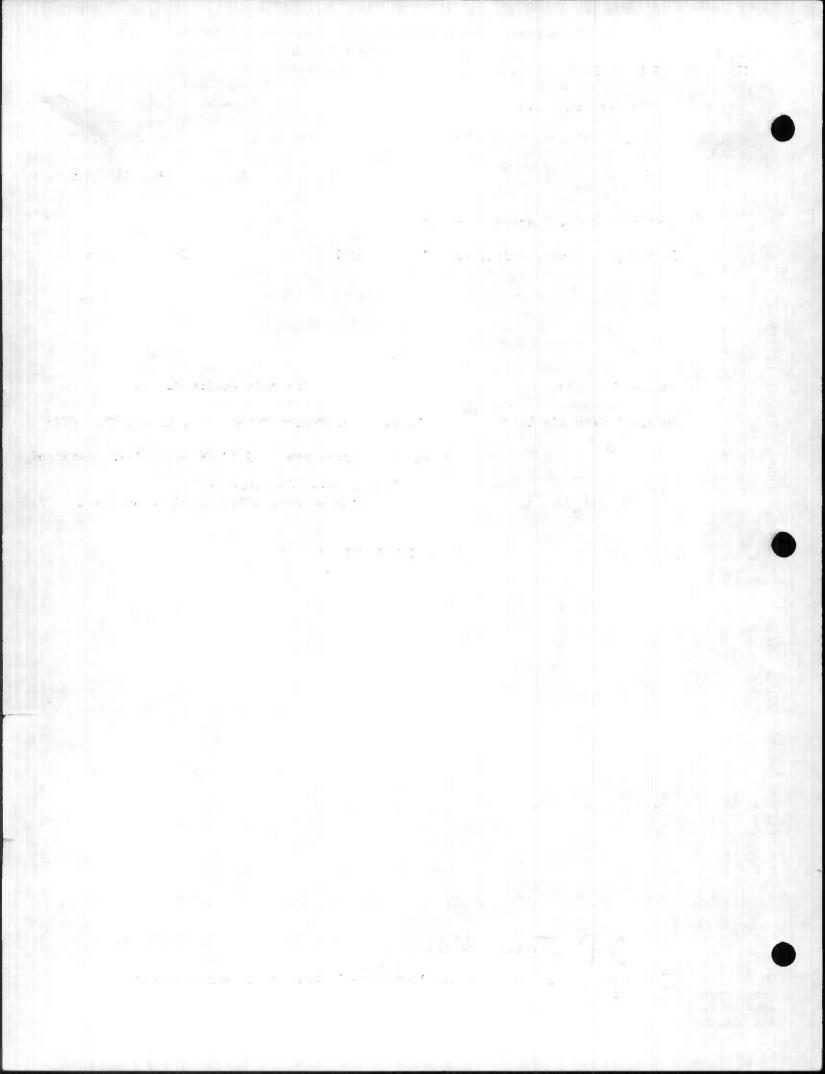
person who completed cause of deeth (Item 23a) (Type, Print)

Pestaner 111 Penn Street, Baltimore, Maryland 21201 OSA 31. Date filed (Month, Day, Year) MAR 1 2 1999

30. Neme and addres

32. Registrar's Signature

Sports



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day **Physician** March 8, 1999 11:30 PM Victoria M. Tewell /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery 4 Spring Hill Court Chevy Chase | If Under 24 Hrs. | 8. Dete of Birth | Hours | Min. | Sept. 21, 1917 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys 1□ M 21 F Yrs. 81 Director 212-34-6127 New York Usuel Residence of Deceden 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic avent, the Medical Examiner must be notified at 1 Yes 2 No Director Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Нета 23а 20815 United States 4 Spring Hill Court Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiena. Ther than "natural", or he 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Remedial Reading Elementery/Secondery (0-12) College (1-4or 5+) 5+ Teacher Tutoring permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked other any Injury or other traumatic avent blues. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be Elizabeth (Unavailable) 10 (Unavailable) Lima 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Christy W. Tewell (son) 2626 Lyon Street, San Francisco, CA 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 【XCremetion 3 ☐ Removel from State 3-9-99 4 Donation 5 Other (Specify) Chesapeake Crematory Beltsville, Maryland 21. Signeture of Funeral Service Licensee, 22. Name end Address of Fecility Rapp Funeral Services, P. A. della 933 Gist Avenue, Silver Spring, MD 20910 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart lailure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) 3 weeks Malnutrition Examiner Due to (or as a consequence of): Physician/Medical Examiner Cerebrovascular Accident 3 weeks The law requires that the death certificate be axecuted physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of): Box 68760. thet initieted events resulting in death) Last Due to (or es e consequence of) signed by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☑ Unknown Records, þ Be Completed 24b. Were sutopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 ☑ No certificata of Vital To the Hospital or Attending Physicien: within 24 hours after deeth.

To the Funerat Director: After this certifica completely filled in by the funeral director, p 25. Wes cese referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner steted. edicai 29a, Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) PHYSICIAN Shameleym. D40804 March 9, 1999 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 10620 Georgia Avenue, #114, Silver Spring, MD 20902 Kewak K. Sharma, M. D.,

**DHMH 16 Rev 6/95** 

State

Registrar

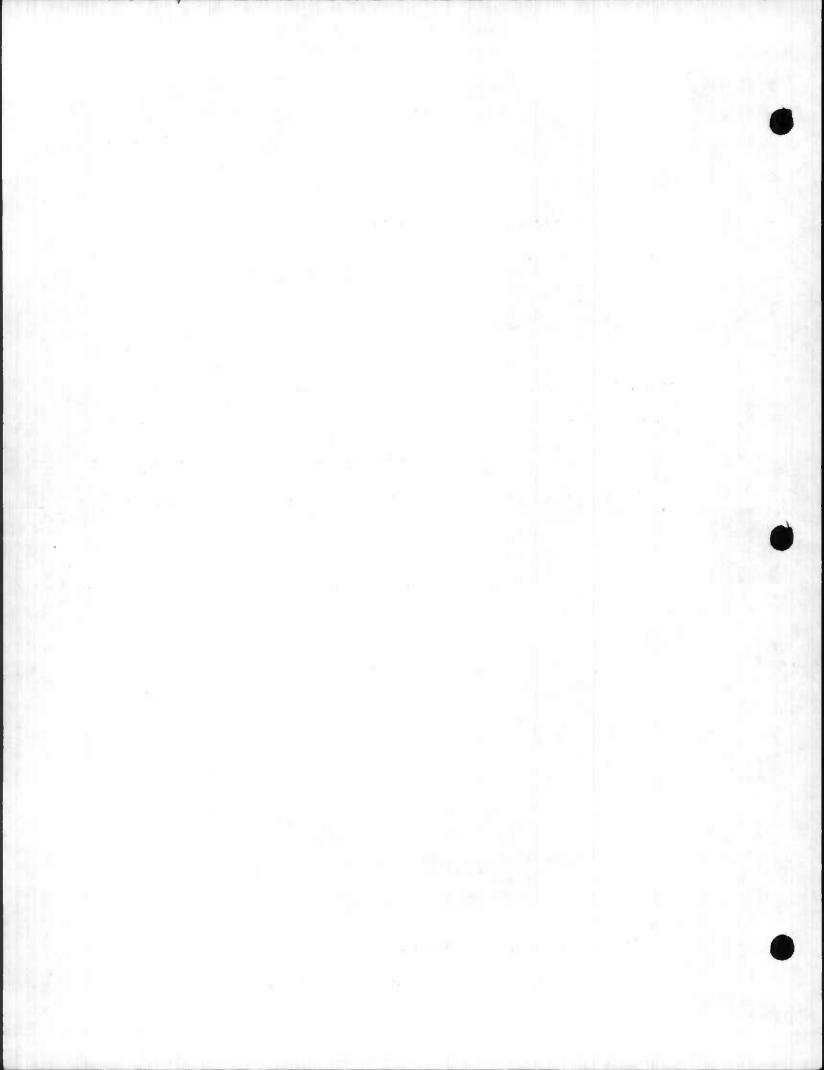
31. Date filed (Month, Day, Year)

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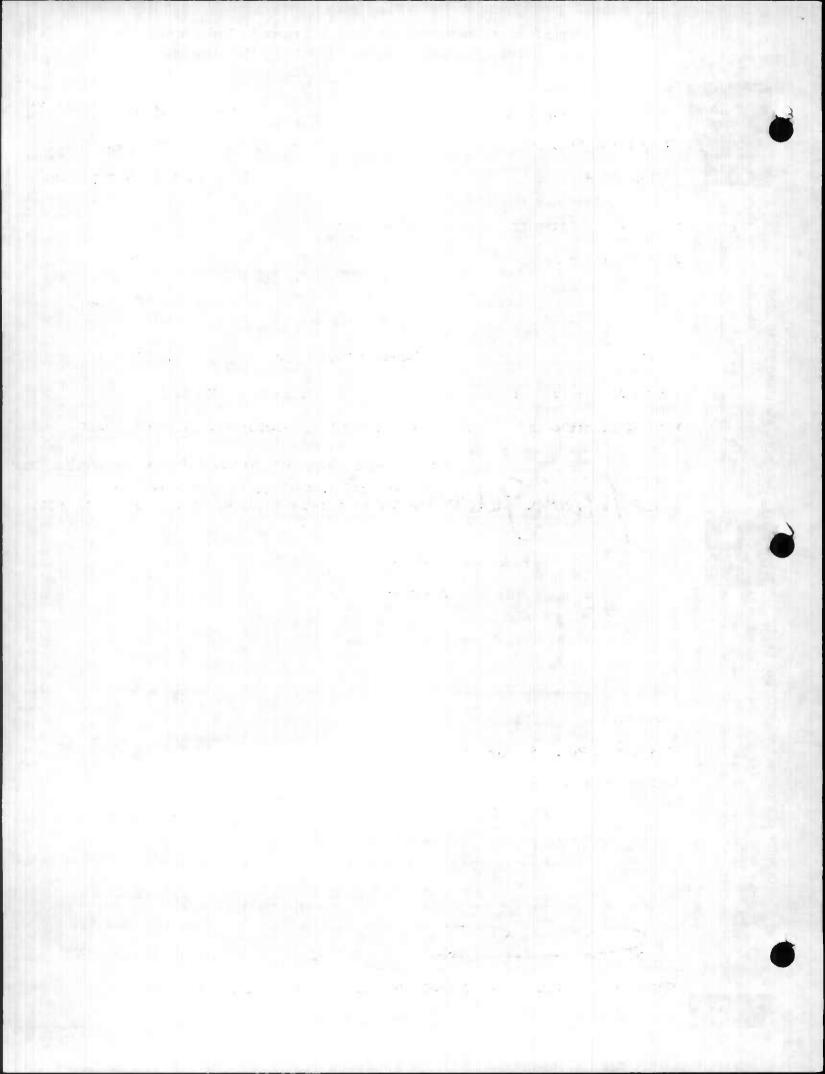
32. Registrar's Signeture

1999



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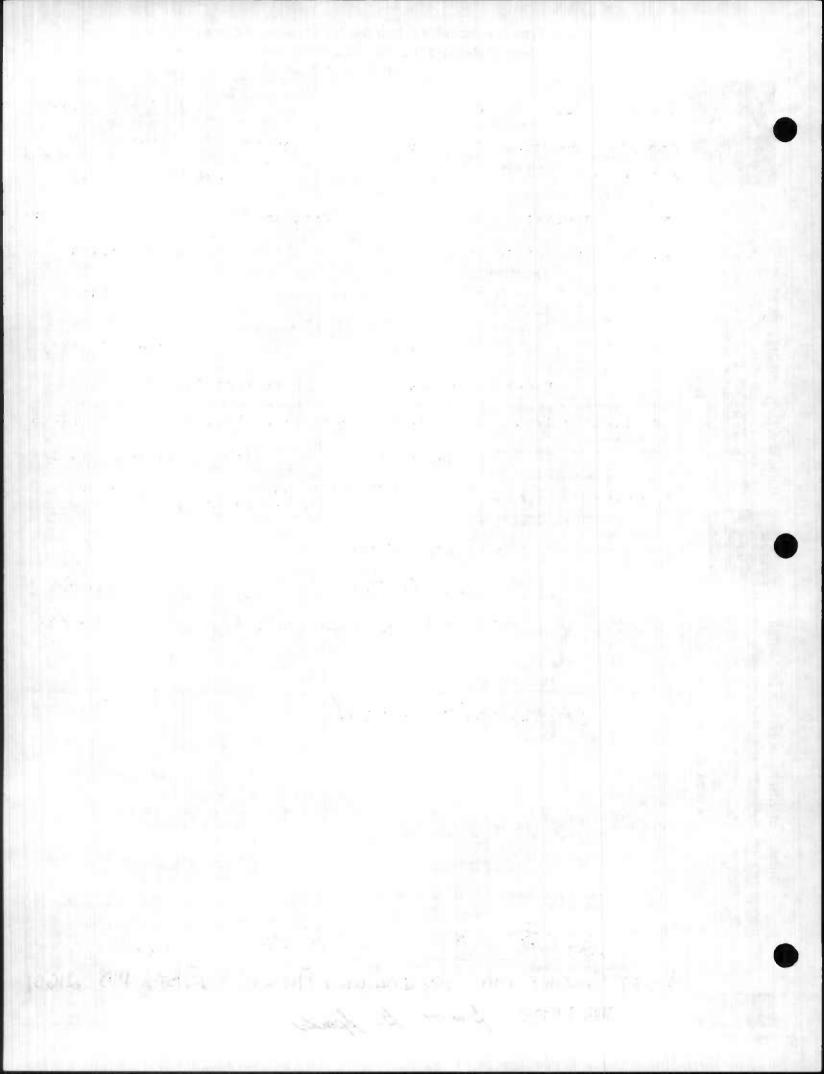


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State of Maryland / Department of Health and Mental Hygiene 99 00000

Physician /Medical Examiner  Funeral Director	Usuel Residence of Decedent	TOW e street and number) Care - Th ex 7. Age	ers				2. Date of Dec Month March	Day	Yeer 99	3. Time of Death 1:50PM
Examiner 5 Funeral 5 Director	Genesis Elder ( 5. Social Security Number 6. S 220-07-3088 1  Usuel Residence of Decedent	e street and number)  Care - Th ex 7. Age	ers				March	/ 12	フフ	I A JUETI
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Maryland H show Hed at tor	7	ŊM 2□F		Yrs. Months	Days		8. Date of Birt (Month, De) 10/04			ace (Stete or Foreig lry) yland
Man Han to to	10a. State 10b. County		10c. City, Tow	n or Location					10	d. Inside City Limit
e 20 0	MD Caroli	ne		101.7	P ip Code	reston		10g. Citizen of V	That Count	1 Yes 3()(N
iter death with the Mai r items 23s or 28s-1 s instruments profiling	22121 Dover B	ridge Ro	a d	101. 21	ib code	21655		United		•
urs after des	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		13. Was Dece If Yes, spe		Hispanic Origin? (S) an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Specify	e - America k, White, e : Wh	
ed within 72 hours ygiene. her than "natural", ft. the Modes Exe Completed by	15. Decedent's Ed (Specify only highest gre		16a	. Decedent's Usu (Give kind of w	ork done	during most of work	king	16b. Kind of Bu	siness/Ind	ustry
5 -3 0	Elementary/Secondery (0-12)	Coilege (1-4or 5-	+)	life. DO NOT	use <i>retire</i>	d)		Grain	2 P	oultry
	8			Farmer		40 Mark and Mar	- (F7A A Sintalla			outery
B se S	17. Father's Name (First, Middle, Last)		Tawan			18. Mother's Nam	Breedi		Θ)	
should nd Men marke		larry M.								
end 2 sho seith end 2.7 la ma er traum	Myra B. Towers		23	2121 D	over	end Number or Ru Bridge				
of of	20a. Method of Disposition  1/3/8urial 2 Cremation 3 C	Removal from State	cemete	of Disposition (Ne	other ple	2	/10	20c. Location -		wn, State aryland
	4 □ Donation 5 □ Other (Specification 21. Signature of Funerel Service Licer		Juni	or Orde		ess of Facility	/10	riesto	11 , 11	aryranu
Physician	23a. Part1. Enter the disease, or comshock, or heart failure. List only	Okaw plicetions that caused one cause on each line		PO BO	ode of dyi	n-Hawkin 13, Fede ing.such as cerdiac	S-ESKO ralsbu or respiretory a	w rune rg, MD	216	Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in deeth)	a	pne to yor as a	consequence of	): .					dois.
nine sir		b	atel	ecta:	515				10	News
ig ph es th	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last	c. NON SV	nall	consequence of	Car	einma	(R)/0	ing	7	norths
at the death cert d by the attendin etached for use Physician/N	Part II. Other significant conditions o		t not reculting	In the underlying	cause di	ven in Part I	23h Did	tohacco usa co	ntribute to	the causs of deal
as that the de igned by the be detached by Physic	cure	broku	la	ncidi	ny			Yss 2□ No	-	pably 4 ☐ Unkno
been s should								an autopsy rmed?	COI	ere eutopsy findings allable prior to mpletion of cause deeth?
The law ete has page 2							10	Yes 2 No	10	Yes 2□ No
0 - 0	25. Was cese referred to medical					26. Plece of Dec	ath (Check only o	one)		
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rthis eraid	27. Manner of Deeth	28a. Date of injury	y. 28b.	Time of Injury	28c. Inju					
tal or Attending Physician: as effer death. and birector: After this certification: To Be Certification: To Be	1 Natural 5 Pending investigation 3 Suicide 6 Could not be			1	Yes 2□No					
	4 Homicide determined	7, 0.1100		City or To						
Hospi 24 hour Funer Funer Stely fill Stely fill	29e. Certifier (Check only one) 1 ☐ Certifying Ph									
To the comple	29b. Signature and title of centilier	se number 25750		29d. Date signe	d (Month,	Day, Year)				
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State	31. Date filed (Month, Dey, Year) MAR 1 0		r's Signature	,				,		
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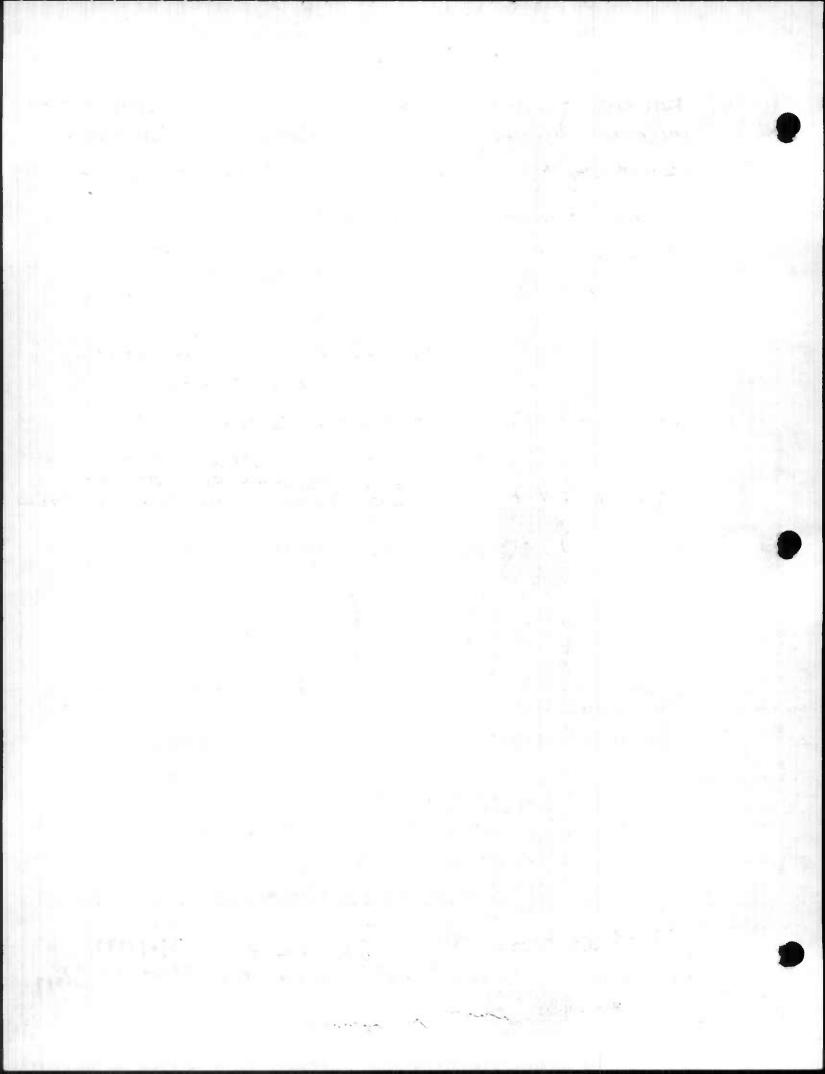
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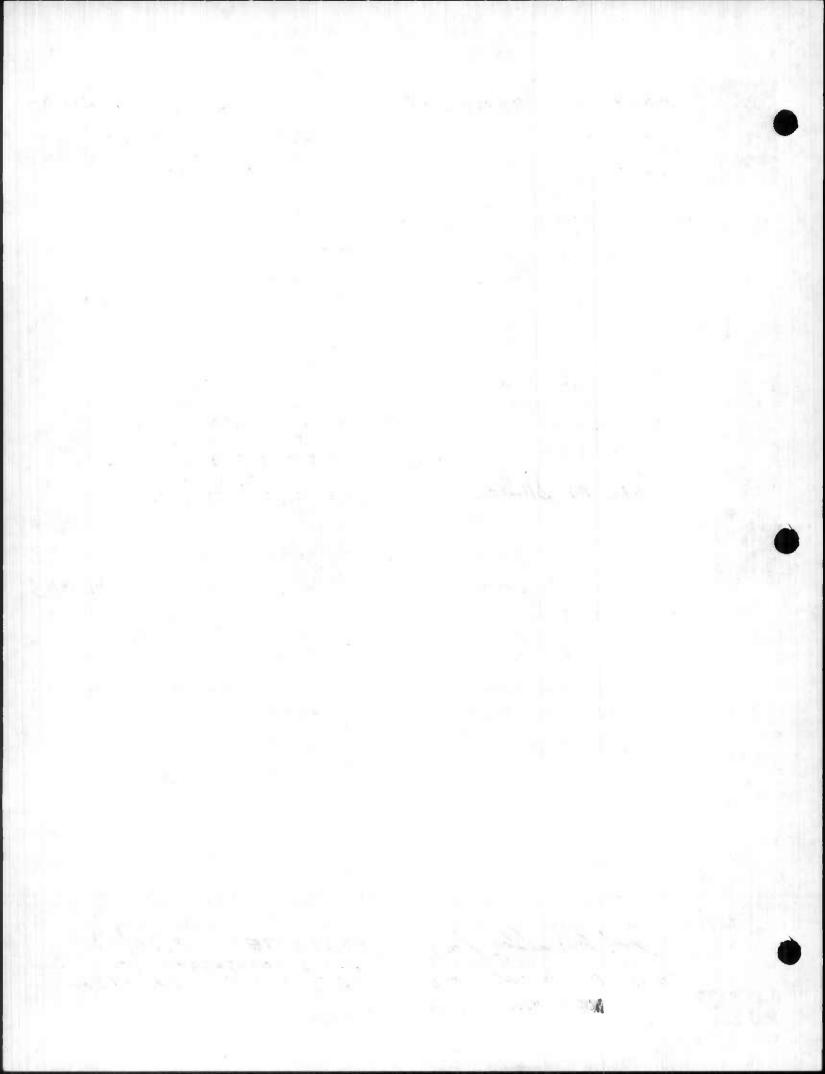
State of Maryland / Department of Health and Mental Hygiene 99 69333

					Cer	tificate c	f Death		Reg. No.	*	03000
	Physic /Med		1. Decedent's Name (First, Middle, Last)  ROLAND ORVILLE	TA	LOF	3		2. Date of I Month	Deeth	qqqq	3. Time of Death 5 02 Am
)	Exami		4a. Facility Name (If not institution, give street end number)  NCCREAPY HOSPITAL.					n, or Location of De S 715 L D	ath 4c. Count	ty of Death	SET.
	Funeral Director		5. Social Security Number スフース4- リブ4 1 M 2 F 7. Age Usual Residence of Decedent	73	birthday) Yrs.	If Under 1 Ye Months Day		Min. (Month,	Birth Day, Year) 25-25		place (Stete or Foreign htry) ginia
	28a-f show	Director	10a. State 10b. County Virginia Accomack	10c. City, To Wa.		ation S Isla	nd			1	0d. Inside City Limits
	3a or 2		10e. Street and Number Atlantic Road			10f. Zip Code 2333			10g. Citizen of U.S.		ntry?
020	in 72 nours arier death with the Meryland "natural", or items 23e or 28e-f show ledgal Example must be notified at	by Funeral	11. Maritei Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E Armed Forces?  1 1 1 2 2 2 3 4 4 5 5 6 5 6 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6		If	/as Decedent of Yes, specify C	uben, Mexicen,	n? (Specify Yes or I Puerto Rican, etc.)	Bia	ece - Americ ack, White,	etc.
15-0		Completed by	15. Decedent's Education (Specify only highest grade completed)	10	(Give k	ent's Usual Oci ind of work doi O NOT use ret	ne during most d	of working	16b. Kind of E	Business/In	dustry
212	then.	Comp	Elementary/Secondery (0-12) College (1-4or 5-				drive	r	transp	porta	ation
5	la de	To Be	17. Father's Name (First, Middle, Lest)  Taylor				Ethe	s Name (First, Midde el Gille	spie		
	trau trau		19e. Informant's Name/Relationship (Type, Print) Mary Katherine Taylor	-				or Rurel Route Num Lantic		n, State, Zip 3 0 3	Code)
altimore,	0 = 0		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State			ition (Name of etory or other p	place)	Date 2/4/GG	20c. Location		
Baltin	Department Important: If any Injury o		4 Donetion 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Johr	22.	-	rs dress of Facility	ev A	1 H	om-	eville VA
			Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. D	o not ente	f the mode of c	HANK lying, such es ce	FOVD HIG erdiac or respiratory	y. Te A	41: 6	Approximate Interval Between
11.	hysician /Medical ixaminer	er	resulting in death)	CAR Due to (or as			FNT	ARCT	1001.		Onset end Death
x 68760,	iding physician end	√Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that injury and a work of the limit steed awarts.	Due to (or as							
			d								
P.O.	has been signed by the atten ge 2 should be deteched for u	/ Physiciar	Part II. Other significant conditions contributing to death but PNEUMONIA	not resulting	in the und	derlying ceuse	given in Pert I.		d tobacco uee co		the cause of death?
of Vital Records, P.O	s been sign 2 should be	Completed by	POSSIBLE SEPSIS.						is en autopsy formed?	av	ere autopsy findings allable prior to mpletion of ceuse deeth?
al R	certificate hare							10	Yes 2 No		]Yes 2□ No
of Vita	is certii directo	To Be	25. Was cese referred to medical examiner?  1 Yes 2 No Hospitai: 1 Inpatien	t 2□ER/0	Outpetient	3□ DOA	Wher	f Death (Check only Ing Home 5 ☐ Re		her (Specifi	v)
O no	h. After this funeral di		27. Menner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day	28b	Time of Injury	28c. In		28d. Describe	how injury occu		,
Division or Attending	aftar deet Director: d in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined building, etc.	y - At home, (Specify)	farm, stree			28f. Location	(Street and Num own, State)	ber or Rura	I Route Number,
Ne Hospita	within 24 hours aftar deeth.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of and menner state	examination a	ge, death o and/or inve	occurred at the stigation, in my	time, date and p opinion, death	place, and due to the occurred at the time	e cause(s) and m	enner as st and due to	ated. the ceuse(s)
To #	within 2 To the comple	W	296. Signature and tale of cartifier day fairhuir	MD.		^	nse number	93	29d. Dete signe	ed (Month, 1	
		ľ	30. Name and address of person who completed cause of det BALA GURUNURTHY, BALAN 31. Date filed (Month Day, York)	LRIST		int)	MAIN	STREET			1 Als 17.
	Sta Registr	te ar	31. Date filed (Month, Pay Year) 0 1999 32. Registrer	s Signature	4.	Spor	1				
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Physic		1. Decedent's Name (First, Mid	ddle, Last)			tificate of		2. Dete of De	Reg. No.		3. Time of Death	
/Med			TR	EMBL	AY			Month 3	Dey	Veer	1:30 AM	
Exam		4e. Fecility Nama (If not institut	tion, give street en	d number)		-	b. City, Town, or	Location of Deet		ty of Deeth		
		17208 RIF	FLE RD.				EMMITS			EDERICK	<	
Funera Directo	_	5. Social Security Number  218-18-5268  Usuel Residence of Decedent	6. Sex 1 □ M 200		s. last birthday) Yrs.	If Under 1 Yaar Months Deys	If Under 24 Hr Hours Mir		, 1910	9. Birthplac Country PENNS	e (State or Foreign YLVANIA	
the Maryland 28a-f show	, o	10e. Stete 10b. Cour			ity, Town or Lo					10d.		
the N	Director	MARYLAND FR	EDERICK		MMITSBU	JRG 10f. Zip Code			10a Citizan of	Mant Country		
ter death with thems 23a or ner mant be	eral Di		IFFLE RD.			2172			U.S.	Α.		
72 hours effer death with the Maryle "neturel", or flems 23s or 28s-f show disal Examiner must be notified as	by Funeral	11. Maritel Status  1 Naver Merried 2 M  3 Widowed 4 Divorce	arried 1 Y	Decedent Evar in I d Forces? as 2 X No , Give or Dates:	1	Vas Decedent of H f Yas, specify Cuba ☐ Yes 2MNo	ispenic Origin? (in, Maxican, Pua Specify:	Specify Yas or No rto Rican, etc.)		ack, Whita, atc.		
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2 should be filed end Mentel Hygi is marked other sumatic event,	ToB	JO					ANN					
		19e. Informent's Name/Relatio									ode)	
- 포 등 등		SHANNON M. W 20a. Method of Disposition			Place of Dispos	sition (Name of		Dete			, State	
8 - = 5		1 ☐ Buriel 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other				e tory or other plea G CREMAT	-	3/11/99	SMITHS	BURG. M	ID.	
permit. Peges 1 er Depertment of Hea Important: if Item 2 any Injury or other once.		21. Signatura of Funeral Service	te Licensad	les	22	Name and Address	ss of Fecility	SKILES	FUNERAL	HOME		
		23a. Part. Enter the disease,	or complications that only one cause	at caused the dea						Ac	terval Between	
Physician /Medical Examiner		Immadieta Ceuse (Finel diseese or condition resulting in deeth)	a. I			CARDI	onyor	PATH)	/	Onsat and De		
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	Please						All Copies A Mental Hygi	-	ble.	19335
				Certific	cate of	Death	Re	g. No.		2000
1. Decedent's Nen	ne (First, Middle, La	st)					2. Date of Death Month		Year	3. Time of Deeth
MARGARI	ET BERY	L TUBMA	N				MARCH	Day 10.19		4:55AM
4a. Fecility Neme	(If not institution, giv	e street end numbe	r)			4b. City, Town, o	r Location of Death	4c. County		4.551111
CIVI	STA MED	ICAL CEN	TER			LAPL	ATA	C	HARI	ES
5. Social Security I	Number 6. S	ex 7. A	ge (In yrs. last b		Inder 1 Yea	r If Under 24 Hi	s. 8. Date of Birth		9. Birtho	place (State or Foreign
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Usual Residence			40.00.7							
10a. State	10b. County			wn or Location					1	Od. Inside City Limits
MD	Charle	S	India	an Hea	ad					1 ☐ Yes 2 💆 No
10e. Street end Nu					of, Zip Code		10	g. Citizen of \	What Cour	ntry?
24 Pot	omac Av	e.		2	20640			USA		
11. Maritai Stetus		12. Was Deceder Armed Forces	t Ever In U,S.	13. Was I	Decedent of	Hispenic Orlgin?	Specify Yes or No- orto Rican, etc.)		e - Americ	an Indian,
1 Never Man		1 Yes 20			es 2 X No				Wh:	
3 Widowed		Year or Dates	:		- 27.10	-py-		Specif)	. WII.	T C C
(Spe	15. Decedent's Ecify only highest gra		166	Decedent's (Give kind	of work done	during most of w	orking 1	6b. Kind of B	usiness/In	dustry
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20e. Method of Dis	sposition		20b. Plece	of Disposition	(Name of			Dc. Location -		
	Cremetion 3		A I	ery, cremator			2/15/00	77.7		3.670
	5 Other (Specification)		11111				3/15/99	walc	ori	, MD
21. Signature of F	Different Service Licer	S .		AREH		ess of Facility	EIMED AT	HOME	T) A	
Nac	red C.	Chab	m60945				FUNERAL			
23a. Part1. Enter	the diseese, or com art feilure. List only	plicetions that ceuse one ceuse on each	ed the deeth. Do line.	not enter the	mode of dy	ing, such as cafti	ac or respiratory arres	بې ۷۰۰	140	Approximete Interval Between
and the latest termination of the latest ter	r=0.00								į	Onset end Death
Immediate Ceuse disease or condition	on	. \_	timet	-						
resulting in death)			Due (or as a	consequence	e of):		<b>^</b> .			
		h 1	hetal	rely	Chu	lun -	- 12mal	t-all	444	
Sequentially list co		D. —	Due to (or as e	consequence	o of):				~	
if any, leeding to ir ceuse. Enter Under Couse (Discoss or	erlying	1	2	1	ten	-			i	
Cause (Diseese or that Initieted event resulting In death)	S	C	Due to (or as a	consequence	P. COLCA	Jen				
ooding in county	Lesi				O				i	
		d								
Pert II. Other signi	ficent conditions o	ontributing to death	but not resulting	In the underly	ring cause g	iven in Pert I.	23b. Did tob	acco use co	ntribute to	the cause of death
1	1		•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			1□ Ye			bably 4 Unknow
- 1-Jen	inter				_					
							24e. Was an perform	autopsy ed?	ev	ere autopsy findings eileble prior to mpletion of ceuse
									of	death?
							1 ☐ Yes	2 1 No	1 [	Yes 2□No
5. Was case references	rred to medical						eath (Check only one	)		
1 Yes 2		Hospital:	ient 2 ER/O	utpatient 3[	J DOA		Home 5 ☐ Resider	ce 6 □Oth	er (Specif	y)
7. Manner of Deat  1 Matural  2 Accident	th 5 Pending Investigation	28a. Date of Inj (Month, D	ury ay Year) 28b.	Time of Injury	28c. Inju	ıryat ork? ]Yes 2 ☐No	28d. Describe how	Injury occur	red	
3 Sulcide 4 Homicide	6 Could not be determined	289. Place of II	njury - At home, f vic. (Specify)	erm, street, fa	actory, office		28f. Location (Stre City or Town,		er or Rura	I Route Number,
29a. Certifier (Check only one)	1  Cartifying Ph 2  Medical Exam	ilner: On the basis	ot examinetion a	e, deeth occu nd/or investig	rred at the t	lme, dete and piac opinion, death occ	e, and due to the cac curred et the time, det	ise(s) and ma e and place,	inner as si	teted. the ceuse(s)
9b. Signature and		end menner s			29c. Licen	se number	29	d. Date signe	d (Month,	Day, Year)
	2 dun	J Bul	, an		Т	0-01009		3-10	-90	7
		- 1 2 700	~ "			, OIOO3		. 0		•

**Physician Examiner** Records, P.O. Box 68760, Division of Vital

been signed by the ettanding physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requiras that the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificata has a completely filled in by the funeral director, page 2 secondly filled in by the funeral director, page 2 secondly filled in by the funeral director, page 2 secondly filled in by the funeral director. Be Completed by Physician/Medical Examiner

Medical Certification: To

**Physician** 

/Medical

Examiner

Director

Funerai

To Be Completed by

**Funeral** 

Director

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health and Mentel Hygiena. Important: If Item 27 is marked other than "natural", or Hems 23s or 28s-1 show any Injury or other traumatic event, the Medical Examiner must be notified at

/Medical

Baltimore, Maryland 21215-0020

TUBMAN

HENRY L.

State Registrar

**DHMH 16 Rav 6/95** 

31. Date filed (Month, Day, Year) MAR 11

BURKE M.D.

32. Registrer's Signature

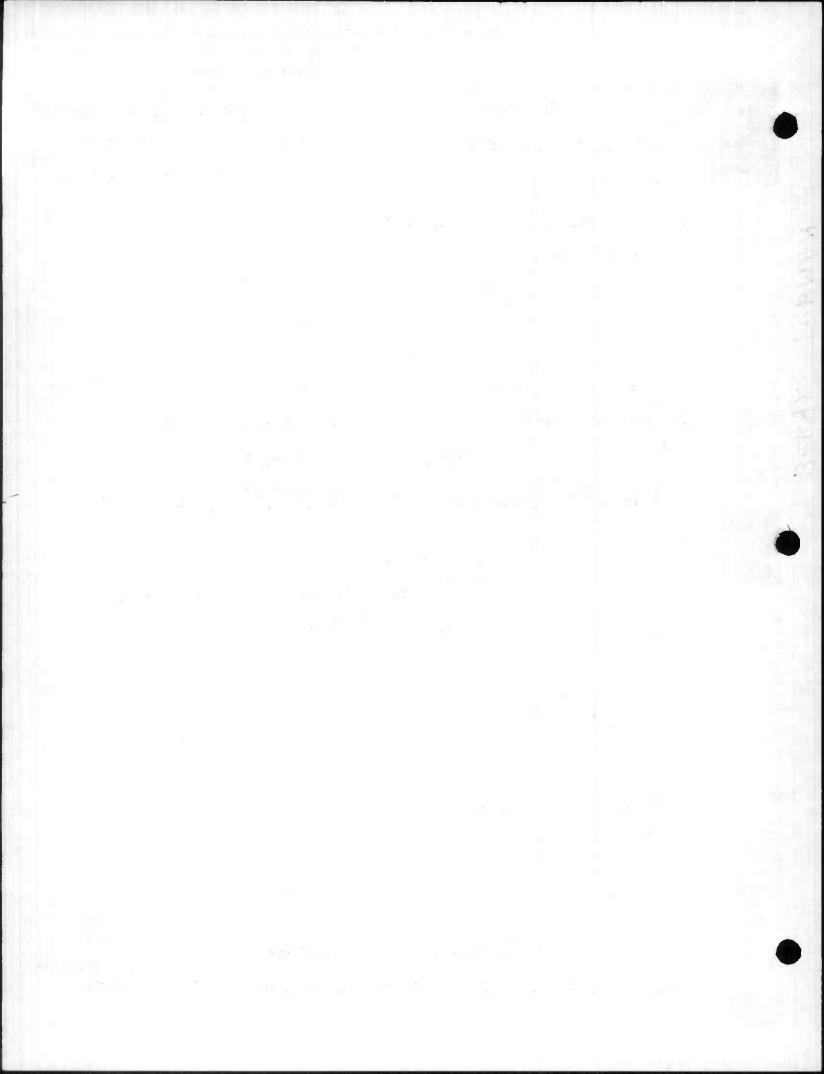
30. Neme and address of person who completed ceuse of death (Item 23e) (Type, Print)

Sporks

115-LA GRANGE AVENUE P.O. BOX 2539

LA PLATA MD.

20646



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Reg No					

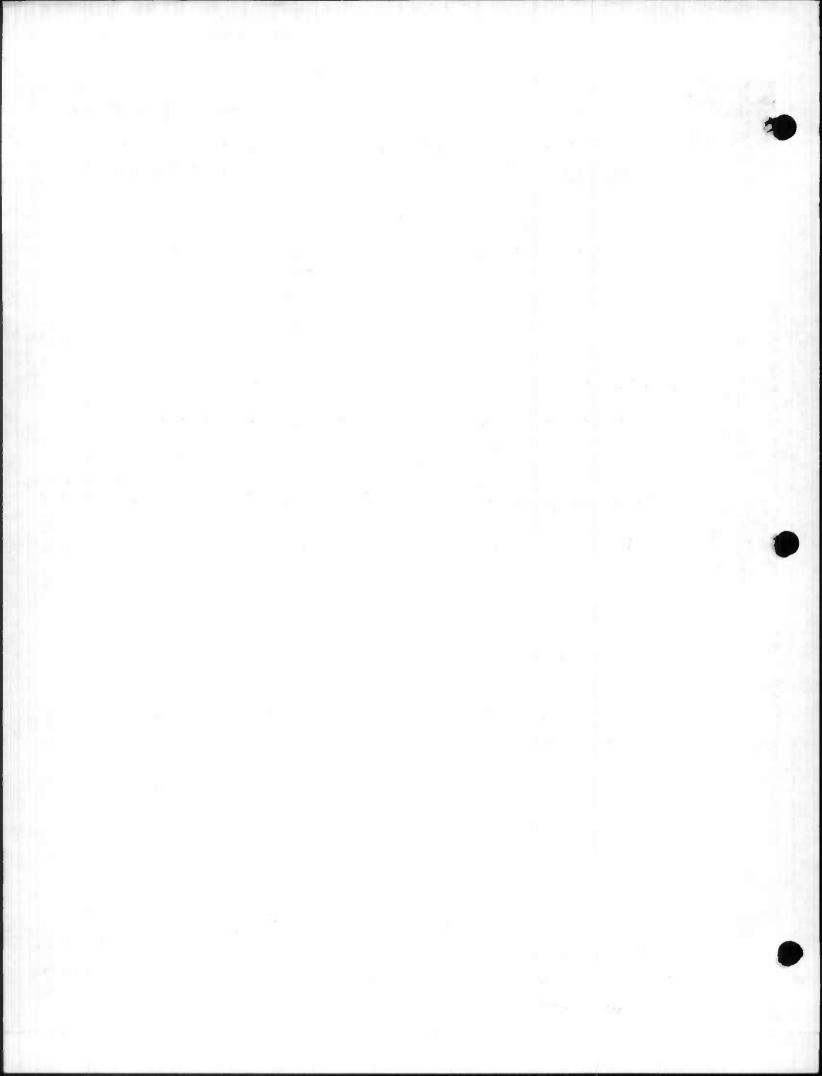
				Cert	ificate	e of	Death			Reg. No.		
	1. Decedent's Nema (First, Me	ddla, Last)					=1110		2. Dete of De		Voca	3. Time of Death
Physician /Madical	Charles Tubbs	Jr.							Month	5, 1	.999	17:01
/Medical Examiner	4e Facility Name (If not institu		mber)				4b. City, To	wn, or L	ocation of Deat		nty of Death	1
	Old Furnace				K Hadas	4 Vaar	Snow				rcest	
Funeral Director	5. Social Security Number  222-46-4899  Usual Residence of Decedant	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. last I		If Undar	Days	If Under Hours	Min.	8. Data of Bir (Month, Da 9-4-1	th ly, Yaar) 968	9. Birthp Cour De Las	olaca (Stata or Foraigi ntry) Ware
and and	10a. Stata 10b. Cou		10c. City, To	own or Loca	ation		1.116				-	10d. Inside City Limits
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Maryland 21215-0020 d 2 should be filed within 72 hours of th and Mental Hygiene. 7 le marked other than "natural", or treumatic event, the Medical Exam To Be Completed by I	15. Dece (Specify only hig	dant's Education thest grade complated)	16	Sa. Decede	ind of won	k dona	during mos	st of work	ing	16b. Kind of	Businass/In	dustry
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and 2: aalth ar n 27 le	Ruth M. Tubbs	, Mother		3686	Snow	w Hi	.11 Rd	1. 5	Salisbu	ry, Md.	2180	4
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Galtin Semit. Pa Separtmen mportant: any injury	4 Donation 5 Othar (Specify)  Springhill Memory Gardens 3-9-98 Hebron, Md.  21. Signatura of Funarai Sarvica Licansaa  22. Nama end Address of Facility											
D SOFT	1 Hopen of	nort-Hen	ninan						e, Inc.	Do 100	040	
Physician / /Medical Examiner	23a. Part1. Enter the disaasa shock, or heart feilura. I Immediata Causa (Finat disaasa or condition rasulting in daath)	list only ona causa on a	Pulse to (or as	a consequ	)/0//) janca of):	<b>N</b> D	7	0	HEA.		6	Approximata Interval Batween Onsat and Death
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The ata h									10	Yas 2KN	1	☐ Yas 2☐ No
sician: The certificate lirector, pag						1		a of Daa	th (Check only	ona)		
Physician: this certific ral director,				Outpatient		-	4 L N	ursing Ho				WICO- ROAD
Attending or death.  ctor: After by the fune iffication	1 Natural 5 Panding (Month, Day Year) Injury Work? 2 Accidant invastigation 3 SSuicida 6 Could not be detarmined 4 Homicide 4 Homicide 28a. Place of Injury - At home, ferm, street, fectory, office 28f. L. C.							28d. Describe how injury occurred  SELT INTELLECTES BUNDSHOT  WOUND STREET AND Number of Rural Routa Number, City or Town, Stata) OLD FURNICE ES				
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Medical Cert	29a. Cariffiar (Check only one)  COUNTY ROAD  Swaw Hill MD 21863  1 Certifying Physician: To the bast of my knowladge, daeth occurred at the time, data end place, end due to the ceuse(s) and menner as stated.  2 Medical Examiner: On the bast of axamination and/or investigation, in my opinion, deeth occurred at the tima, data and place, and due to the cause(s) and mannar stated.											
To the within To the comple	29b. Signeture and title of cert		worth.	M. D	g, 29c.		se number	41		29d. Dete sig	ned (Month,	
	30. Nama and address of pers	on who complated caus	a of death (Itam 23a	a) (Type, P	rint)	). a	203	SN	ow Si	. Sno	u Hre	4 Mo. 2/8
State Registrar	31. Data filed (Month, Day, Ya MAR 0.		egistrar's Signatura	5	Sp	ock	2					4 Mo. 18

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State of Maryland / Department of Health and Mental Hygiene

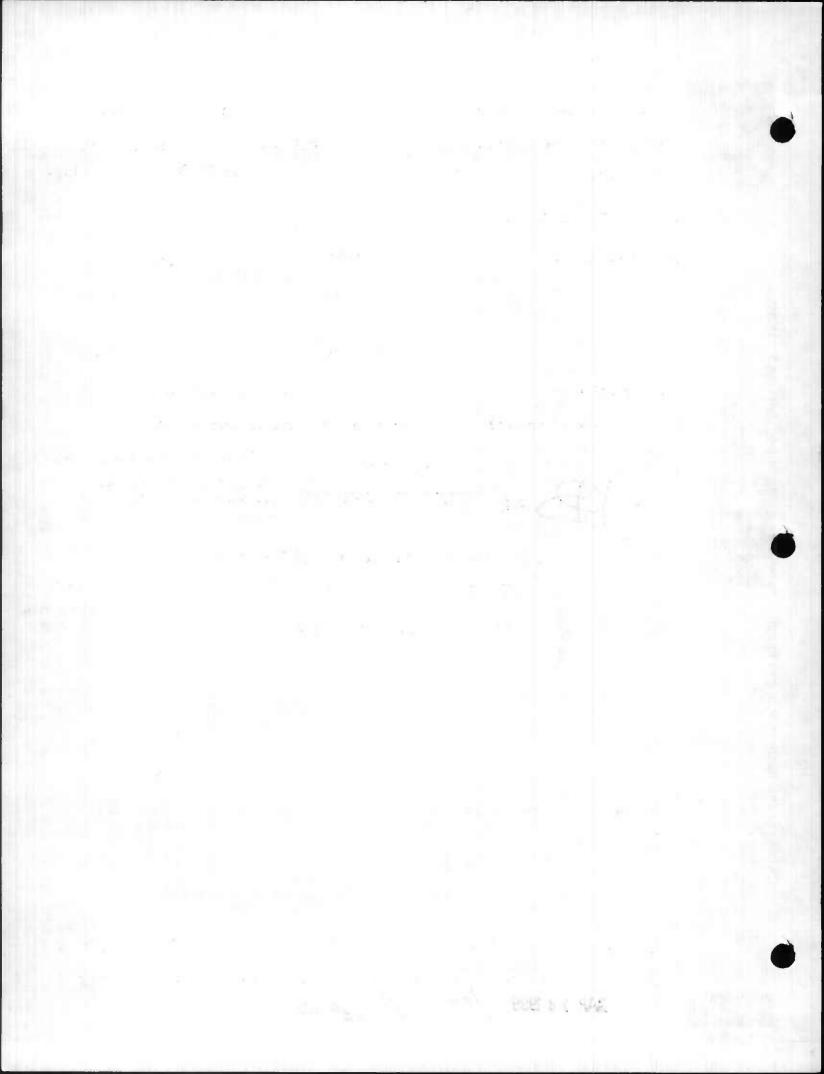
						Certificate d	of Death		Reg. No.		
	Div1-		1. Decedent's Name (First, Middle, Lo	est)		200		2. Dete of Dee	eth _	/aaa	3. Time of Deeth
	Physic /Medi		Augusta Tucker	Townsend				MARC/-		799	0700
	Examin Funeral Director		084-03-9612	Advențist	Hosp (In yrs. lest b		4b. City, Town, or L ROCKV i ear If Under 24 Hrs. lys Hours Min.	.11e	Monto	JOME 9. Birthpi	ery lece (State or Foreign Tana
pue	3		Usuel Residence of Decedent  10e. Stete 10b. County		10c. City, Tov	m or Location				10	od incide City Limite
he Maryla	r 28a-f show	Director	Varyland		-	more City					Od. Inside City Limits  1 Yes 2 No
ath with t	r items 23a or 3 iner must be n		100 Street end Number 100 West Univers				)		10g. Citizen of Wh United S		•
Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Maryland	"natural", or items soical Examiner n	by Funeral	11. Meritei Stafus  1 □ Never Merried 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Wes Decedent E Armed Forces? 1  Yes 2 No If Yes, Give Yeer or Detes:		13. Was Decadent if Yes, specify C	of Hispanic Origin? (Sp Cuben, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Rece- Bieck, Specify:	White, e	
2-C	natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	166	Decedent's Usuei Oc (Give kind of work do	ne during most of work	ing	16b. KInd of Busin	ness/Ind	ustry
within	r than	mpl	Elementary/Secondary (0-12)	College (1-4or 5+	+)	<i>life. DO NOT</i> use <i>re</i> Vriter	tired)		Book Auth	hor	
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2 sho	- B		19e. informent's Neme/Relationship				eet and Number or Rur			tete, Zip	Code)
9 - S	m 27		H. Stewart Cobb,	Jr. (nephew			325, Mobile	, Alaba	ma 36616		
Baltimore,	Department of Health Important: if Item 27 any Injury or other trongs.		20a. Method of Disposition  1) Burial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Speci		cemete	of Disposition (Name of ary, cremetory or other nne's Cemet	plece)	/99	20c. Location - Ci Annapoli:		
Demit.	Import any in		21. Signeture of Funerel Service Lice	CM. Bo	Den		of Glouces				
Dh			23e. Pert1. Enter the disease, or con shock, or heart feilure. List only	plications that caused to one cause on each line	the death. Do	not enter the mode of	dylng, such es cardiec	or respiretory er	rest,		Approximete Intervai Between Onsel end Deeth
/\	ysician Jedicai aminer		immediate Ceuse (Finel disease or condition	, pur	TISYS	TEM OR	GANFAIL	UNE			IDAY
^	amme	Je.	resulting in deeth)		,	consequence of):					10A4
D, executed	physician end s the burial-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	bSEP		consequence of):					•
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. 0	ed for	sicia	Pert II. Other significant conditions	contributing to death but	not resulting	n the underlying cause	given in Pert I.	23b. Did t	obacco use contr	ributa to	the cause of death?
requires that the	igned by the etter be detached for i	by Physician/						1 101	res 20 No 3	Prob	ebly 4 Unknow
necords,	peen s	Completed t	Chronic	true Le	eng	Disease	2	24e. Wes perfor	en eutopsy med?	con	re sutopsy findings elleble prior fo enpletion of cause death?
The la	ate has page 2	E O						101	es 20 No	1	Yes 2□ No
	certificate rector, pag	Be C	25. Wes case referred to medical				26. Plece of Deet	th (Check only o	ne)		
	0 0	To	exeminer? 1 ☐ Yes 2 ☑ No	Hospitel: 112 inpatien	f 2 ER/O	utpetienf 3 DOA	Other: 4 Nursing Ho	ome 5 Resid	lence 8 Other	(Specify	,)
or Attending Phys	arter deem.  Director: After thi d in by the funeral	ation:	27. Manner of Deeth 1		Year) 28b.		njury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow Injury occurred	1	
Lal or Att	al Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home, fa (Specify)	arm, street, factory, offi	ice	28f. Location (S City or Tow	Street end Number m, Stete)	or Rural	Route Number,
To the Hospital	within 24 hours and To the Funeral Dir completely filled in	edical	29e. Certifier ↑ Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best of miner: On the besis of e end manner state	examinetion ar	e, deeth occurred at the nd/or investigation, in m	e time, dete end pleca, ny opinion, deeth occur	end due to the o	euse(s) end mann dete end pleca, an	ner as sta d due to	ated. the ceuse(s)
Toth	To th comp	5	29b. Signeture end fitte of cartifier	hand	2.441	29c. Lio	ense number D30	112	29d. Dete signed ( INAR CH	Month, E	Jey, Year) 1999
			30. Name and address of person who VIRENDRA SAXEW 31. Dete filed (Month, Dey, Year)	completed cause of dec	eth (Item 23e)	(Type, Print)	NG COUR	7, BETH	HESDA 1	MO	20817
	Sta Registr	_	31. Dete filed (Month, Dey, Year) MAR 1 0 1	999 32. Registrer	's Signeture	B. Spa	eks)		-		



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		SM AACO			Certif	ficate of	Death	2 Date of D	Reg. No.		3. Time of Deeth
sician		me (First, Middle, L						2. Date of De Month	Day	Yaar	
tical	Theod						4b. City, Town, or	Location of Deet	h 4c. County	1999	8:50am
iner	Branch Control	(If not institution, g						Location of Deet			
	5. Sociel Security	n Marylan		al Cen 7. Age (In yrs.		f Undar 1 Yaar	Clinton If Under 24 Hrs	8. Date of Bir	Prince	George George	ges ace (State or Forai
	164-12-8		1□M 24戸F	78	Yrs.	fonths Days	Hours Min	12-22	20°	Count	P.A.
	Usuel Residence										
_	10e. State	10b. County			y, Town or Locati	ion				10	od. fnside City Limi 1 ☐ Yas 2 🖔 N
Director	MD		Georges	C.	linton						
Dire	10e. Street end No					10f. Zip Code			10g. Citizen of \	What Count	ry?
Funeral		rratts Ro		dont Ever in LI	C 12 Was	20735	Hispenic Origin? (5	Specify Vee or No	USA 14 Bac	e - Amarice	an indien
Š	11. Marital Status	rried 2 Married	Armed For		ff Ye	es, specify Cub	an, Mexican, Puar	to Rican, etc.)		ck, White, e	
2	11.11	4 Divorced	If Yes, Giv Yeer or Da	9 **	10	Yes 22 No	Specify:		Specify	/: Whi	te
ē	A	15. Decedent's	Education		16e. Deceden	t's Usuai Occu	pation	addam.	16b. Kind of B	usiness/Ind	ustry
Completed	Elementary/Sec	condery (0-12)	College (1	-4or 5+)			during most of wo	nking			
Con	88				Н	lousewii				emake	r
Be	17. Fether's Name	(First, Middle, La:	st)				18. Mother's Na	me (First, Middle	, <i>Maid</i> en Sumeп	10)	
2		Filiaggi			1			ica Aug		0	0.44
		Name/Relationship				- Short sent	end Number or A				Code)
	Nancy A.	Rowe (D	augnter)	20h F	/011 G		n Drive C	linton	MD 20735 20c. Location		wn. Stata
	TE bullat 2	Sposition 2 ☐ Cremation 3 5 🖾 Other (Spec	Removal from		emetery, cramet	ory or other pla	ice)	3-9-199			
				- Cuit	Glen Hav	en and Add	and Facility				e, MD
	21. Signature of 1	Uneral Service Lio	011000	7	/ 22.N	arile and Addi	ess of Facility Si	ngleton	Funeral	Home	
	One Post Esta	VA	Xels	en			ve. S.W.			D 210	Approximete
п	shock or he	the disease, or co	ly one cause on e	ach line.	n. Do not enter t	ine mode or dy	ing, such es cardie	ic or respiratory e	niost,		Interval Between Onset and Deeth
	fmmediate Cause	(Final	_	-							2 2000
	diseese or conditi resulting in death		e. <u>C</u> E		OVAS (U		ACCE	DENT		-   -	DAYS
Jer			7		mic		FARCT	1402		2	DAYS.
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EX	Sequentially list of if any, leading to it cause. Enter Und Cause (Disease of	immadieta derlying	A-	THEIR	OSCLE	= 12 6 0	T 4.			i Y	1 YEAR
dicai	thet initiated even resulting in daath)	IS	C		r as a consequar		-				+ / = //
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lan/			d								
by Physician/M	Part II. Other sign	ificant conditions	contributing to de	ath but not res	ulting in the unde	erlying cause g	ven in Part i.				the cause of dear
Ph								1	Yes 2 No	3 Prot	pably 450Unkno
								24e. Wes	s an eutopsy		ere autopsy finding
(f)								perf	ormed?	COI	pilable prior to mpletion of cause deeth?
et								10	Yes 2 No		Yes 2 No
ompiet			1				26 Diago of D	eeth (Check only			, 100 ZUNU
e Completed	25. Was rasa rate	erred to medical			ER/Outpatient	3□ DOA O	hor	Home 5 ☐ Res		ner (Specifi	()
Be	25. Wes case reference examiner?		Hospital:	patient 2			- sur riving	1100			
To Be	examiner? 1 Yes 25	No ath	28e. Data (	of Injury	28b. Time of	28c. Inju	iry at	28d. Describe	now injury occur		
To Be	examiner?	No	28e. Data (Mont				nryat ork? ]Yes 2 ☐ No	28d. Describe	now injury occur		
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State of Maryland / Department of Health and Mental Hygiene 9 9 3 3 9

				Certifica	te of	Death		F	Reg. No.	· ·			
Physician	Decedent's Neme (First, Middle,	*					2	Data of Dea Month	Day	Yeer	3. Time of Death		
Physician /Medical	SUZANNE P.	ULMAN						ARCH	8, 1999		10:45 A.		
Examiner	4a Facility Nama (If not institution, I		)				wn, or Loca VER SI	tion of Death		of Death	Y		
E			ge (In yrs. last bin	thday) If Und	er 1 Yaar								
Funeral Director	722-16-3927 Usual Residence of Decedent	1□M 2₹F 7		Yrs. Months	Days	Hours	Min.	EPT. 2	8, 1920	WASH:	lace (State or Foreig try) LNGTON, DO		
Maryland	MD 10b. County MONTGOM	ERY	10c. City, Town							1	0d. Inside City Limit		
ttar death with the Maryla r Itama 23a or 28a-f ehov ingr. must be nottlied at ingred Director	10e. Street and Number 3618 LITTLEDALE	ROAD			ip Code 895				10g. Citizen of V	What Cour	itry?		
urs a	11. Marital Status 1 Nevar Marriad 2 Married 3 WWidowed 4 Divorced	12. Was Decedan Armed Forces 1 Yes 2 M If Yes, Give Year or Dates:	? [No	13. Was Dec If Yes, sp	ecify Cul	ban, Mexican	, Puarto Rio	fy Yes or No- can, etc.)	Bled	e - Americ ck, White, /: WH			
led within 72 hours ygiena. Per than "natural", rt, the Wedesl Ex Completed by	15. Decedent's (Specify only highest Elementery/Secondery (0-12)	Education grade completed) College (1-4or		Decedent's Us (Giva kind of w life. DO NOT	ual Occu ork done use retire	pation during mos ed)	t of working		16b. Kind of Bo	usiness/In	dustry		
od within	Elonion (o 12)	3+		MEMAKER					OWN HO	ME			
0 = 0 > 8	17. Father's Name (First, Middle, La								Maiden Suman	na)			
d 2 should be the end Mente 7 is marked traumatic • To E	JOHN FREDERICK		105	Adatta - Addres	- (01			DE HUN		Ctata Tie	Codel		
nd 2 saith er trau	19a. Informent's Name/Relationship CRAIG H. ULMAN	SON	10	4 PRIMR	OSE				, MD 20		(000)		
0 4 4 4	20e. Method of Disposition  1 Burial 2 X Cramation 3  4 Donation 5 Other (Spe		cameter	ORE/WAS	other pla	GTON	3/	Date /12/99I	20c. Location -	- Julian			
permit. Pege Department of important: If any injury or bnce.	21. Signature of Funarel Service Lie	censee .	OKLANI	JOSEPH					5130 W	ISCON	ISIN AVEN		
	NW, WASHINGTON, D.C. 20016  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.												
Physician /Medical Examiner	Immediata Cause (Final diseasa or condition resulting in deeth)  ASPIRATION PNEUMONIA  Due to (or as a consequence of):  SEIZURES  b.												
certificate be axecuted ding physician end isa as the bufal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	b	Due to (or as a	consequenca of	):	41	1			i	B 54		
Sing Sing	that Initieted events resulting in death) Lest	d	Dua to (or es a c	consequence of	):								
deeth e ettar ed for u	Part II. Other significant conditions	iven in Pert I		23b. Did tobecco use contributs to the cause of de									
requiras the seen signe hould be d	Λ́α a							24a. Was en eutopsy performed?  24b. Were autopsy findin availeble prior to complation of cause of death?					
The law ate has b page 2 s								1 U Y	as 200No		Yes 2□ No		
iclan: The certificate rector, pag	25. Wes case referred to medical examiner?					26. Place	of Death (	Check only o	ne)	1			
5 0 D	1 ☐ Yes 2 No	Hospitai:	ient 2 ER/Ou	tpatient 3 0	JUA		rsing Home	a 5 Resid	lence 6 Oth	ar (Specil	y)		
Attanding or death.  • ctor: After by the fune iffication	27. Manner of Deeth    Square   Pending   2   Accident   3   Square   2   Accident   3   Square   4   Homicide   4   Homicide   4   Homicide   2   Accident   2   2   Accident   2   2   2   No   2   2									al Route Number,			
To the Hospital or within 24 hours after To the Funeral Dir. Completely filled in Medical Cert	29e. Certifier 10 Certifying (Check only one)	time, dete en oplnion, dea	City or Town, Stata)  dete end place, end due to the cause(s) and manner as stated. on, death occurred et the time, date and placa, and due to the cause(s)										
within on the comple	and manner stated.  29b. Signature end title of cartifier 29c. Lic							1	29d. Date signe	d (Month,	Day, Year)		
	1	1300	MID		00	nh"	78		MAI 9	199	14		
12	30. Neme and address of person wi	o completed cause of	death (Item 23a) (	(Type, Print)	110	(1//	Son	iva M D	14901	, , , ,	1		
	CAJEEU BATLA	MO 10	801 Lo	Kwoud	yr-	Julien	0/11/	al web	00101				
State Registrar	31. Date filed (Month, Day, Year) MAR 1 2 1		trar's Signature	6. de	pack	2							

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State of Maryland / Department of Health and Mental Hyg	jiene 9	9	U	9

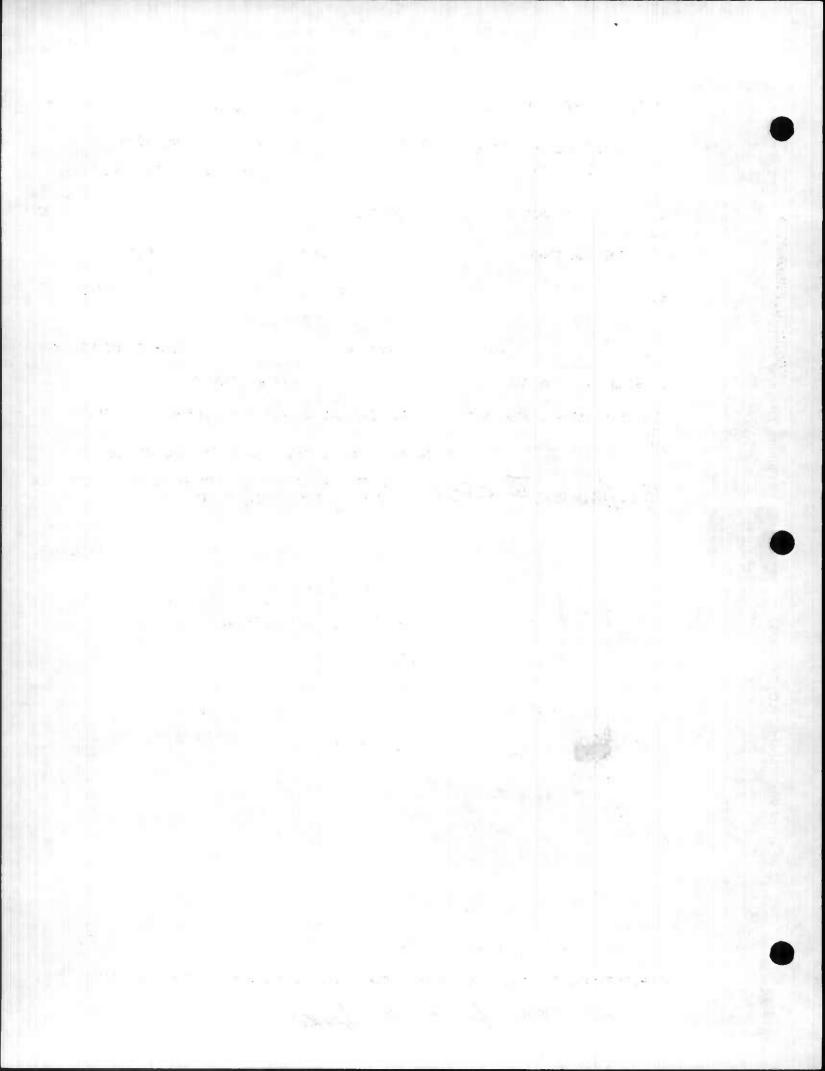
340 Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** FREDERICK VANE VOSHELL MARCH 9 1999 0255AM /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number 5. Sex HOSPITAL & EASTON TALBOT If Under 1 Yeer 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1₩M 2□ F 88 Yrs 217-07-5134 Director AUG. 26, 1910 MARYLAND Usual Residence of Decadent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or items 23s or 25s-4 show trsumstice event, the Medical Examinar must be notified at CORDOVA 1 Yes 2 No TALBOT MD Director Maryla NO STEFT-1005 REDERICK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 12252 VOSHELL ROAD 21625 Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 N No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Status 1 Never Married 2 Married WHITE 1 Yes 2 No Specify: Specify by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOME CONSTRUCTION 11 -0-CARPENTER permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumatic event page. 18. Mother's Neme (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Be ANNIE HOPKINS ULYSSES G. VOSHELL 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) ELLSWORTH ANDREW/ PER. REP. 31744 TAPPERS CORNER ROAD, CORDOVA, MD 21625 altimore, 20b. Placa of Disposition (Name of cametery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 Cremetion 3 Removal from State WOODLAWN MEMORIAL PARK 3-12-99 EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrese of Facili 21. Signature of Funeral Servica Licansee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 200 S. HARRISON ST., EASTON, MD 21601 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel month ulmonary edema disease or condition resulting in death) Examiner Due to (or es e conseguence of): Examiner Les tive heart forfure for al fibrillation certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Frail P.O. Box 68760 Physician/Medical as a consequence of): 88 OP 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 100 signed by t 1 Yes 2 No 3 Probably 4 Winknown rreumonia Division of Vital Records, by 24b. Were autopsy findings available prior to 24a. Wes an autopsy Completed Chronic renal inoufficience completion of cause of death? has page 2 Im. 1 Yes 2 No certificate 25. Was case referred to medical examiner?

1 Yes 2 XNo Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 2 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After Natural Accident Attending 5 Pending s after death. 1 Yes 2 No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 4 ☐ Homicide 6 To the Hospital o within 24 hours af To the Funeral Di 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, end due to the cause(s) end manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53406 aleren 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) MICHELLE D'ABREU, M.D., 920 MARKET STREET, P.O. BOX 496, DENTON, MD 21629 31. Date filed (Month, Day, Year) 32. Registrar's Signature State B. Sparker Registrar MAR 1 0 1999

**DHMH 16 Rev 6/95** 

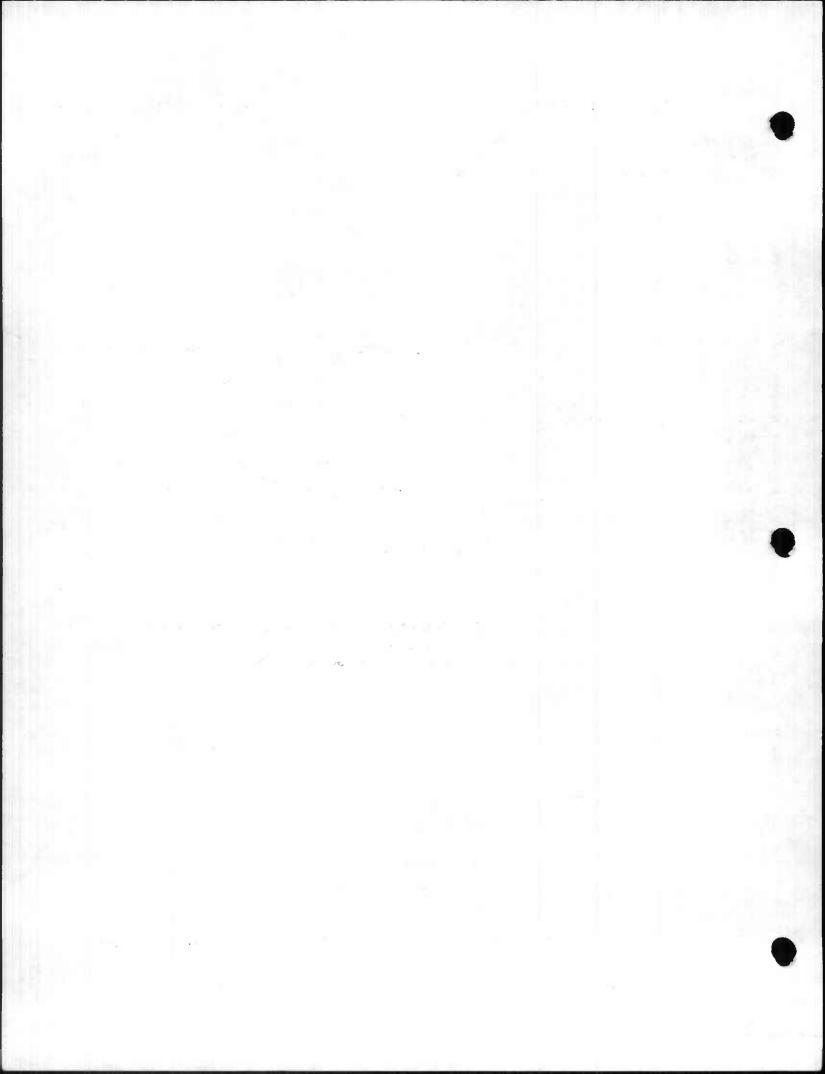


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State of Maryland / Department of Health and Mental Hygiene 99

				Certifica	ate of	Death		Reg. No.	0334		
Di cicio	1. Decedent's Nama (First, Middle,	Last)					2. Data of D	eath Day	3. Tima of		
Physician /Medical	Philip Raymond	Ward, Sr.					March		8:36		
Examiner	4a Facility Nama (If not institution,	give street and number)				4b. City, Town, or	Location of Dea	th 4c. County			
	10908 Stillwater	Avenue				Kensingt	on	Montg	omery		
Funeral Director	006-18-2991	1 TH 2 F	(In yrs. lest bir	Yrs. If Unc Month	ler 1 Year s Days		(Month, D	1, 1923	Birthplaca (State or Country)     Maine		
d 2 should be tiled within 72 hours efter death with the Maryland th and Mental Hygiene. 7 te marked other than "natural", or fterna 23s or 28s-f show traumatic event, are Marical Exercitor must be notified as To Be Completed by Funeral Director	Usuai Rasidence of Decedant		10c, City, Town	a na I nantina					1011 11 00		
	10a. Stata 10b. County		TOC. City, Town						10d. Insida Cit		
	MD Montgon	nery		Kensi	ngtor	1			I Tas		
	10e. Street and Number			10f. 2	Zip Code			10g. Citizen of V	/hat Country?		
	10908 Stillwater	Avenue			20	0895		USA	A		
	11. Marital Status  1 □ Nevar Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1		,S. 13. Was Decedent of Hispanic Origin? (Sr If Yas, specify Cuban, Mexican, Puarto 1 ☐ Yes ♣☐ No Specify:				Specify Yas or No- nto Rican, atc.)  14. Race - Ama Black, White White Specify:			
		15. Decedent's Education (Specify only highest grade completed) entery/Secondery (0-12)  College (1-4or 5+)			16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Businass/Industry		
4 6		5+	A	rchivi	st			Nationa.	l Archives		
arked otherstic event.	17. Father's Nama (First, Middle, La Patrick Henry Wa			18. Mothar's Nama (First, Middle, Lucy Ellen W				Θ)			
th and Mental 7 is marked of traumatic even To Be	19a. Informant's Name/Ralationship Philip R. Ward,			ling Address (Street and Number or Rural Route Number, City or Town Stillwater Ave., Kensington, MI							
E	20a. Mathod of Disposition		20b. Place of	Disposition (A	lame of		Dete	20c. Location -	City or Town, Stata		
0 ± 0	1 Burial 2 Cramation 3			y, crematory o	-		2/0/00	A 1 J			
125	4 Donation 5 Other (Spe		Metro	olitan			3/8/99	Alexand	ria, va s Funeral		
Department of Health and Department of Health and Department of Health and Department of Health and Department of Other training or other	21. Signature of Funaral Sarvice Lic	Tuver.		Home,	Inc	. 500 Uni	versity 20901	Blvd.,	West		
	23a. Part1. Entar the disease, or co shock, or haart ailura. List on	mplications that caused ly one cause on each lin	the death. Do r	not enter tha m	ode of dy	ing, such es cardia	c or raspiratory	arrest,	Approximate Interval Baty Onset and D		
	Immediata Causa (Final disease or condition resulting in death)  Myocardial Infarction							1 hour			
5			Oue to (or as a o			7.00					
nsit nln	Arteriosclerotic Heart Disease							3 year:			
and -tra	Sequentially list conditions, if any, leading to immediate										
og physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c. Insulin dependent diabetes mellitus w/peripheral 23 years										
the state	that initiated evants rasulting in death) Last Vascular disease										
0 0											
or ut									1		
the a	Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceusa given in Part I.  23b. DId tobacco usa contributions							ntributa to the causa o			
igned by the attending be detached for use a by PhysiciaryM		1 ☐ Yaa 2 ဩ No 3						3 Probably 4 0			
should should				366				s an autopsy ormed?	24b. Wara autopsy fi available prior to completion of co of daath?		
							10	Yas 2 No	1   Yas 2		
	25. Was case referred to medical					26 Place of Do					
director o Be	axaminar? 1 ☐ Yas 2(XNo	Hospitai:	nt 2 ER/Ou	tnationt 20	004	her	eth (Check only		or (Spanital		
27. Manner of De 1 Dishatural 2 Accident 3 Suicide	27. Manner of Death	1 ☐ Inpatier		tpatient 3	DUA	4 LI Rursing	1	how injury occur			
	2 ☐ Accident investiget	ion	(Month, Day Year) tnjury Work?  I □ Yas 2 □ No								
	determined					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	(Check only 2 Medical Ex	Physician: To the best of aminer: On the besis of and manner stat	axamination and								
To the	29b. Signature and title of certifier	Λ .		2	9c. Licen	se number		29d. Data signer	i (Month, Day, Year)		
4	b Company MA				D37678			March 8, 1999			
~	James Ma	o completed assessed to	ath (Non-20)	Trans Saint							
0	30. Nama and addrass of parson wh						0001				
	James Mackin, MD			., Was	hing	ton, DC	20015				
State	31. Data filed (Month, Day, Year)	QQ 32. Hogistra	r's Signature	9. 1	na H	1					

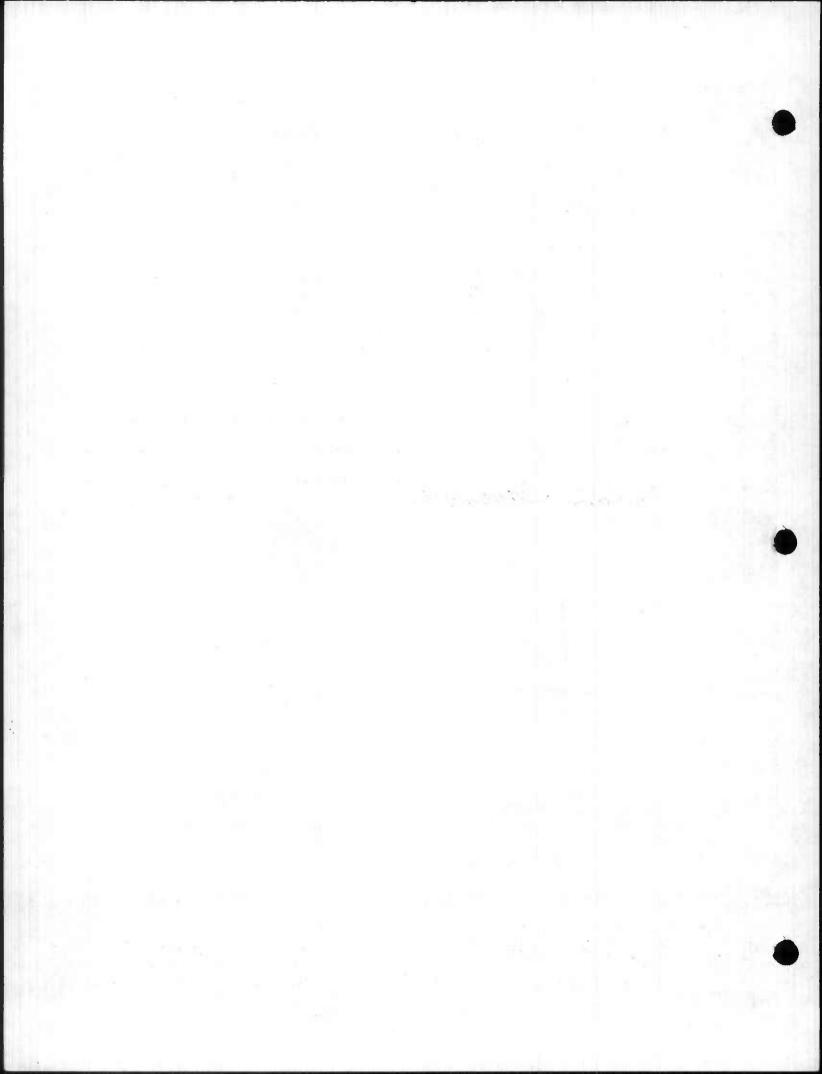
DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Date of Daath 3. Time of Death **Physician** MARKETH Pay 1900 FRED C. WERBER 8:00 A.M. /Medical 4a. Facility Name (If not institution, give street end number)
HEBREW HOME OF GREATER WASHINGTON 4c. County of Death MONTGOMERY 4b. City, Town, or Location of Daeth Examiner ROCKVILLE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Aga (In yrs. last birthdey) 9. Birthpiaca (Steta or Foraign **Funeral X**□M 2□ F PENNSYLVANIA Director 118-22-9464 Usuei Rasidance ot Decadant the Maryland 10c. City, Town or Location ROCKVILLE permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Depertment of Health end Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination must be notified at 10a. Stata MARYLAND 10d. Inside City Limits MONTGOMERY Director 1 ☐ Yas XXNo 10e. Street and Number 10f. Zip Coda 10g. Citizan ot What Country? 6121 MONTROSE RD. 20852 USA Funeral 12. Was Dacedent Ever in U.S. Armed Forcas? 1 ☐ Yas 2 TANo it Yas, Giva Yeer or Datas: 11 Maritai Status Was Dacedant of Hispanic Origin? (Specify Yas or No-it Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indien, Biack, White, atc. Gealtimore, Maryland 21215-0020 1 ☐ Yas 2 ♥ No Specify: þ Specify: WHITE 3 ☐ Widowad 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education 16b. Kind of Businass/Industry (Specify only highast grada completed) Elementary/Secondary (0-12) Coilege (1,4or 5+) ENGINEER TEXTILE 17. Father's Nama (First, Middle, Lest) 18. Mothar's Nema (First, Middla, Maidan Surnama) Be FRED C. WERBER LORNA BLOOM 2 19a. Intormant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 20303 CROWN RIDGE CT., GERMANTOWN, MD 20876 RICK WERBER SON 20a. Method of Disposition 20b. Piaca of Disposition (Nama of 20c. Location - City or Town, Stata MT. COMFORT CEMETERY 1 Buriai 2 Cramation 3 Ramovai from State ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 3/8/99 21. Signeture of Funaral Sarvice Licensee 22. Nama and Addrass of Facility
DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Entar the disaasa, or complications thet causad of daath. Do not antar tha mode of dying, such as cardiec or respiratory errast, shock, or haart failure. List only one cause on each line **Physician** /Medical CEREBRAL HEMORRHAGE Immadiata Cause (Finei 2 HOURS disaase or condition rasulting in death) **Examiner** HYPERTENSION Examiner physician and the burial-trensit Sequantially list conditions, if any, laading to immediata causa. Entar Underlying Ceusa (Disaasa or injury thet initiated avants rasulting in daath) Last Box 68760, Physician/Medical Dua to (or es e consequança of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobacco use contribute to the cause of death? DIAASTES MELLITUS TYPE 2 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy tindings eveilebla prior to completion of causa of death? 24e. Wes an autopsy periormed? Completed SUBACUTE CEREBRAL ANGIOPATHY page 2 1 Yas 2 No certificate 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Was casa ratarred to medical exeminar? 26. Piaca of Death (Check only ona) Hospital: Othar: Nursing Homa 5 Rasidanca 6 Other (Specify) 1 Yas 2 No Medicai Certification: To 1 ☐ inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA s qu 27. Mannacef Deeth 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Natural 5 Panding invastigation after death. 1 Yas 2 No 2 Accidant 6 Could not be datamined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, straat, factory, offica building, atc. (Specify) To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th 28t. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and dua to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, dete end place, and dua to the cause(s) and manner stated. 29a. Cartifiar (Check only one) 29b. Signature end titie of certifie 29d. Data signed (Month, Dey, Year) MARCH 05, 1999 30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print) ockVILLE MD 20852 PATEL M.U. 6121 MONTROSE 31. Data tiled (Month, Day, Year) 32. Registrar's Signature State

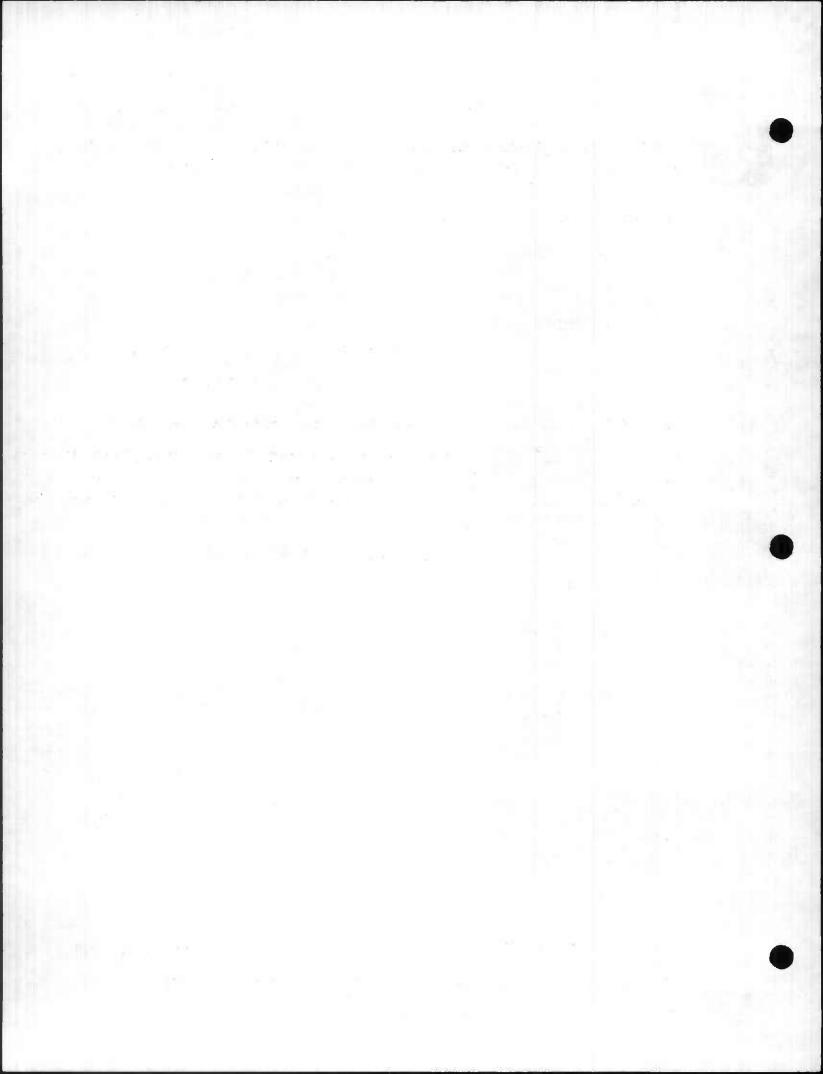
Registrar

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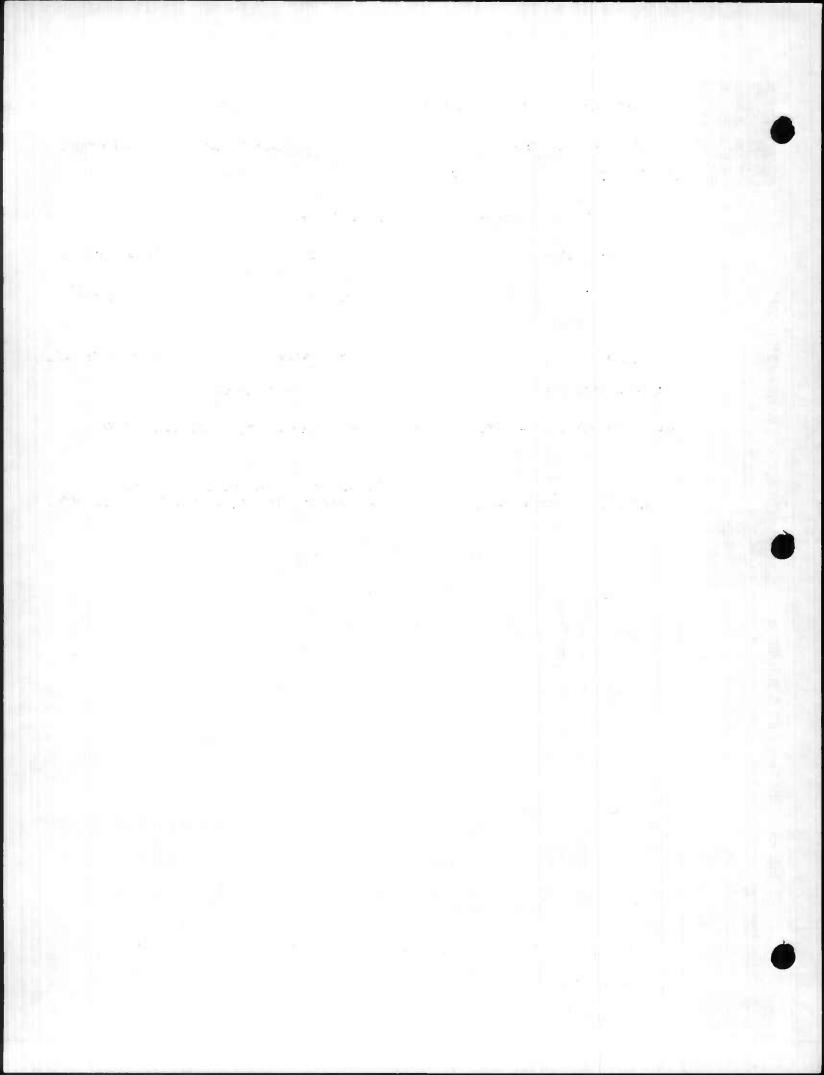
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 99

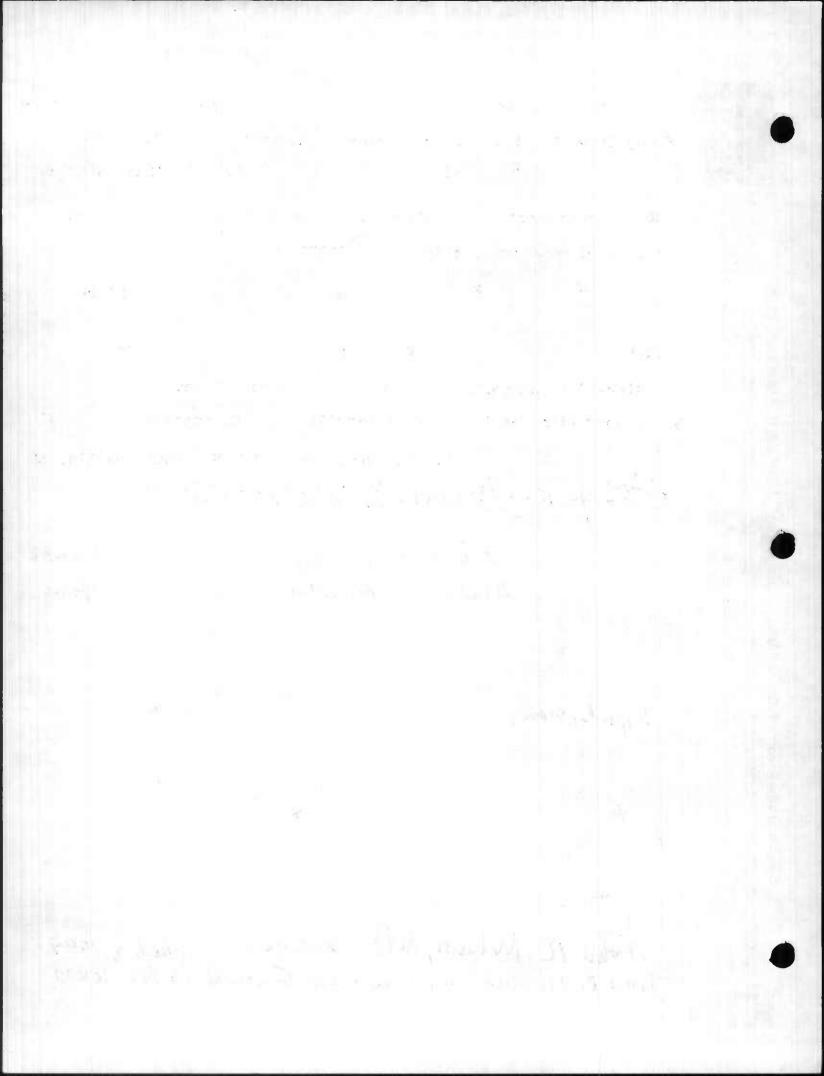
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 6:30 am MILLEDGE WILLIAMS 5, 1999 L. MARCH /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Temple Hills
If Under 24 Hrs. 8. Date of B 4507 Cedell Place Prince Georges If Under 1 Year 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min. Months MM 2DF Deys Hours Director 49 May 12, 1949 251-84-1938 SC Usuel Residanca of Deceden the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at Prince Georges Temple Hills He Yes 2 □ No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4507 Cedell Place 20748 United States Funeral nit. Pages 1 end 2 should be filed within 72 hours after death actment of Haalth and Mantal Hygiene. ortant: If item 27 is marked other than "natural; or theme 23 in properties to the properties of the properti 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Bleck, White, etc. 1 ☐ Never Married 2 ☑ Married 1 XYes 2 ☐ No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 Yes ≥ No Specify: **Black** Specify: þ 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 12th Truck Driver Private Industry 18. Mother's Name (First, Middla, Meiden Sumeme) 17. Fether's Nama (First, Middle, Last) Milledge Williams Mary Fisher 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 4507 Cedell Place, Temple Hills, MD 20748
of Disposition (Name of Date 20c. Location - City or Town, Stete Geraldine Williams - Wife 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any injury or 3/13/99 4 ☐ Donetlon 5 ☐ Othar (Specify) Greenwood, SC Gate of Heaven Cemetery 21 Signature of Funeral Service Licensee 22. Name end Address of Fecility
R. N. Horton Co. Morticians, Inc. 600 Kennedy Street, N. W., Wash., DC 20011 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician Esophageal /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Examiner coh (18m physician and the burial-transit that the death certificete be axecuted Sequentially list conditions, if eny, laading to immadiata cause. Enter Underlying Ceuse (Disaasa or injury thet initieted events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of) Division of Vital Records. P.O. Box 68760 Physician/Medical 85 USB 6 signed by the a Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed has 1 Yas 2 No 1 Yas 2 No certificate Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certific funeral director, Be 25. Wes case raterrad to medical 28. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Lo 1 Yes 2 KM6 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Data of Injury (Month, Dey Year) 27. Manriar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending invastigation Natural 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To tha best of my knowledga, daeth occurred et tha tima, data and placa, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daeth occurred at the time, data and place, end due to the causa(s) end manner steted. 29a. Certifier Medical To the To the To the I 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. License number 30. Name and eddress of person who complated cause of daeth (Item 23e) (Type, Print) Temple Itills, NO ranch filed (Month, Day, Year) 32. Registrar's Signeture State MAR 1 1999 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 9 9345

				arylaria / c	Certificate of	of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Reg. No.	Ο.						
Physic /Medi		Decedent's Name (First, Middle, Last     RACHEL A			100.00		2. Date of De Month MARCH	Dey	Yeer 999	3. Time of Death 6:30 PM					
Exami		4a Facility Name (If not institution, give					Location of Deet								
		Shady Grove Re				Rockv			TGOM						
Funeral Director		214-12-1312	X DM <b>2</b> €DF 7. Ag	e (In yrs. last bir 84	Yrs. Months De		Feb.	18,191	5 Cour	plece (State or Foreign try) laryland					
pue m		Usuel Residence of Decedent  10a. State  10b. County		10c. City, Tow	n or Location			10d. Inside (							
a-1 sh	ctor	MD Montgom	ery	Gait	hersburg	J				XXYes 2 No					
fier death with the Marylen r items 23s or 25s-4 show	al Director	10e. Street end Number 403 W. Diamon	d Ave.,	#104	10f. Zip Cod 2 C	877		10g. Citizen of V	Vhat Cour S.A.	•					
	by Funeral	11. Maritel Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify C	of Hispenic Origin? ( cuban, Mexican, Pue No Specify:	Specify Yes or No rto Rican, etc.)	Bled	e - Americ k, White, Bla						
72 hours	Completed	15. Decedent's Edu (Specify only highest grad		16e.	Decedent's Usual Oc (Give kind of work do life. DO NOT use re-	cupation ne during most of w	orking	16b. Kind of Bu	ısiness/în	dustry					
within ene.	mp	Elementery/Secondary (0-12)	College (1-4or	)+)	iife. DO NOT use rei Domestic	tired)		Но	me						
	ပိ	17. Father's Name (First, Middle, Last)			201110110	18. Mother's Na	3. Mother's Name (First, Middle, Maiden Sumame)								
Maryland d 2 should be file th end Mentel Hy 7 is merked othe treumstic event	To Be	Richard H.	Stewart			Rac	hel Pos	sey	-						
shou and M mer	_	19a. Informant's Name/Relationship (T)		eet and Number or F											
C = CI L		W. Gregory Wims	(Son)	6	428 Danvi	ille Ct.	, N. Be	ethesda	, MI	20852					
altimore, mit. Pages 1 en partment of Heal portant: If Item 2 y Injury or other		20a. Method of Disposition  133 Burial 2 ☐ Cremetion 3 ☐ F  4 ☐ Donetion 5 ☐ Other (Specify)	lemoval from State	cemete	Disposition (Name of y, crematory or other ce Grove	place)	Date 3/9/99	20c. Location -							
Baltimol permit. Pages Department of Important: If it any injury or o		4 Donetion 5 Other (Specify)  Brooke Grove Cem. β/9/99 Laytonsville, MI  21. Signature of Funeral Service Lloons  22. Name and Address of Facility  SNOWDEN FUNERAL HOME, P.A.													
)		23a. Part1. Enter the dispuse, or compleshock, or heart failure. List only or	icetions that caused	the death. Do		LLE, MD dying, such as cardi				Approximate					
Physician	10	shock, or heart failure. List only or	ne cause on each li	ne.						Interval Between Onset and Death					
/ /Medical		Immediate Cause (Final disease or condition	ta	h. Las	tion					NIONKC					
Examiner	8.	resulting in deeth)	90	Due to (or as a	consequence of):					e weeks					
P #	iner		A1-	Lomer	s demo	entia				2 weeks Years					
og / 60, cete be executed physician and the buriel-transit	Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Obsease of Injury  Due to (or as a consequenca of):													
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Hecords, P.O. Box he law requires that the death cer s has been signed by the attendir age 2 should be deteched for use	Completed							an eutopsy ormed?	av	fere eutopsy findings vailable prior to ompletion of cause death?					
The law ate has page 2	EO.						10	Yes 2110	1	☐ Yes 2☐ No					
VICAL The sicilars The certificate irector, pag	Be	25. Was case referred to medical examiner?				26. Place of D	eath (Check only	one)							
- 5 v 0	70	1 Yes 2 No	fospital: 1   Inpatie	ent 2 ER/Ou	tpetient 3 DOA		Home 5□Res	ldenca 6 □Oth	er (Speci	fy)					
on o	on:	27. Magner of Death  ↑ SNatural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. 1		njury at Work?	28d. Describe	how Injury occur	red						
SIO Seath. Tor: A	cati	2 Accident investigation 3 Sulcide 6 Could not be				1 ☐ Yes 2 ☐ No	not transier	(Ot		al Carta March					
LIVISION  or Attending after death.  Director: After d in by the fune	Certification:	4 ☐ Homicide determined		ury - At home, fa c. (Specify)	rm, street, factory, offi	ce		(Street and Numb wn, State)	er or Hur	ar House Number,					
UVISION To the Hospital or Attanding it within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifying Physics of the Certification Physics of the Certif	sician: To the best ner: On the basis of and menner st	exemination en	, death occurred at the d/or investigation, in m	e time, date end plac ny opinion, deeth occ	ca, and due to the curred et the time	ceuse(s) end me dete end plece,	enner as s	stated. o the ceuse(s)					
o the	Me	d (Month,	Day, Year)												
5		John R	. Nels	up, 1	M)	19294	4.57	March	5,	1999					
		4.5	LNICK	eeth (Item 23e)	Russell A	ve. GA	thershu	irg. Mi	1 2	0879					
Sta Regist		31. Date filed (Month, Day, Year) MAR 0 9 199		ar's Signature	5. Span	KN									



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev Yeer Rosetta Copper Wilkins 9 1999 1550 March 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death The Memorial Hospital Talbot Easton If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 25 F Months 216-38-8733 Jan.8,1921 Md. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 XYes 2 No Md. Talbot Easton 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 212 Port street 21601 U . S . A . 14. Race - American Indian, 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give<sup>2</sup> Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🌠 No Specify: Specify: **Black** 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementery/Secondery (0-12) College (1-4or 5+) Domestic Private Family 07 17 Father's Name /First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Copper Lola Jenkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Roselee Hayman/Daughter Preston, Md. 21655 21616 Dover Bridge rd. 20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, crematory or other place) Dete 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Richardson Mem.Prk. 3/13/99 Easton, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee 22 Name and Address of Fecility East Use. 322 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. 21601 Approximete Interval Between Onset and Death Immediate Cause (Final month disease or condition resulting in death) Due to (or es e consequence of): ensure Due to (or es a consequenca of) Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

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To the Hospital or within 24 hours aft To the Funeral Dil completely filled in

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Certification:

Medical

Box 68760.

Records, P.O.

Division of Vital

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**Physician** 

/Medical

Examiner

10a State

**Funeral** 

Director

r than "naturel", or items 23a or 28a-f show the Wed cal Examiner must be notified at

filed within 72 hours after Hygiene. ther than "naturel", or ite

permit. Pages 1 and 2 should be filed Department of Health and Mentel Hygi Important: If item 27 is marked other eny Injury or other treumatic event, II

Directo

Funeral

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Completed

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Wilkins

Rosetta Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Physician/Medical þ Completed

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. terescleroni with Ed 25. Wes case referred to medical examiner?
1 ☐ Yes 2 ☑ No 28. Plece of Death (Ch

24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

eck only one)	
5 Residenca	6 ☐Other (Specify)

Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manyler of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 1\ Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 [If Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

29b. Signeture end title of cartifier

4 - Homicide

(Check only one)

29e. Certifier

29c. License number

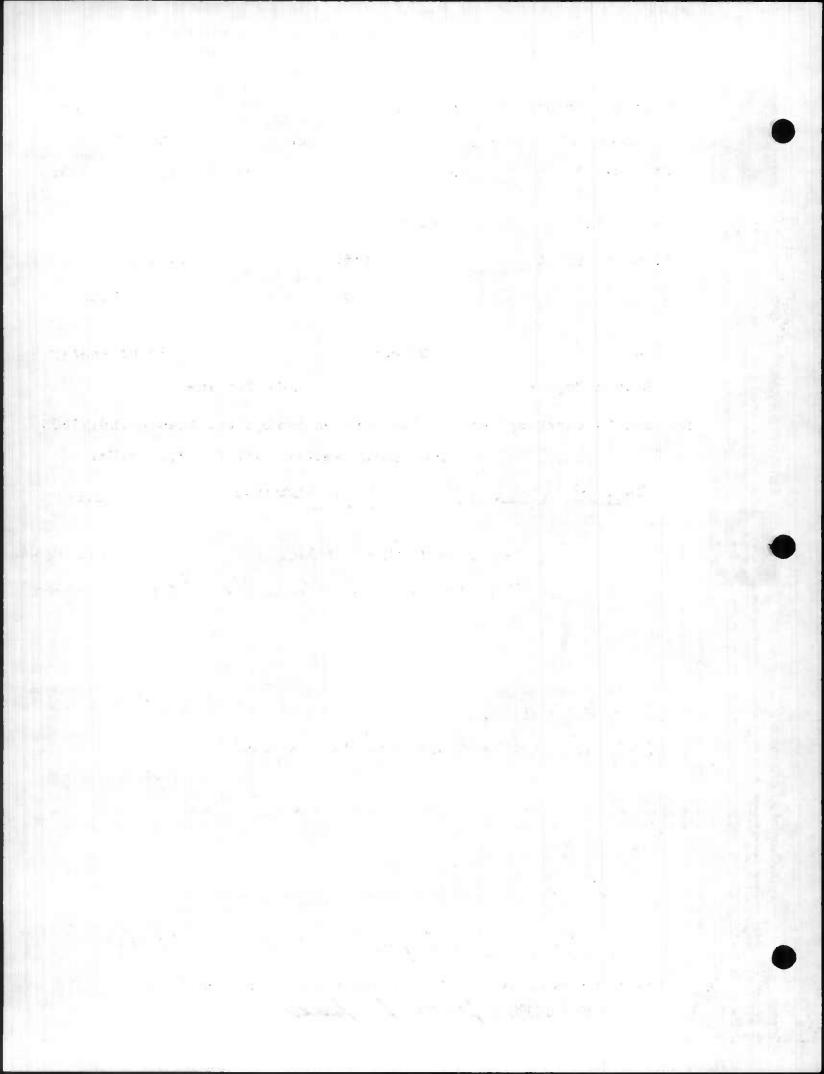
2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

William H.Wood Jr.MD 506 Idlewild Ave. Easton, Md. 21601 31. Date filed (Month, Day, Year) MAR 1 0 1999 32. Registra's Signature

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth Month Yeel **Physician** MARCELLA WILLIAMS MARCH 7, 1999 7:45pm /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MARVEL HALL- WILLIAM HILL MANOR TALBOT EASTON 5 Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) NOV • 20, ] 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 21XF Months Deys Hours Min Yrs. MÄRYLAND Director 215-14-3610 80 1918 Usual Residence of Decedent the Maryland 10e. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner number to notified at TALBOT MD EASTON 1 Yes 2 □ No Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code ò 23a 501 DUTCHMAN'S LANE 21601 USA Funeral death Herrs . 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No It Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer c Deperment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic svent, the Medical Exercision 2016. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: WHITE þ 3 ☑ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 -0-HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) JAMES THOMAS MULLIKIN LILLIAN LARRIMORE 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3316 JAMAICA PT. RD., GEORGE F. DULIN, JR./ SON TRAPPE, MD 21673 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete Nuriel 2 Cremetion 3 Removal from State WOODLAWN MEMORIAL PARK 3-11-99 4 ☐ Donetion 5 ☐ Other (Specify) EASTON. MD 21. Signeture of Funerel Service Licensee 22. Name end Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. erf1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cerdiac or respiratory errest, shock, or heart teilure. List only one cause on each line. CFSI tntervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed physician end s the buriel-tren Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence ot) Physician/Medical Due to (or es e consequence of) 98 ettending for use es signed by the d Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco uee contribute to the cause of death? 1⊠Yes 2□ No 3□ Probably 4□ Unknown þ 24b. Were autopsy findings eveileble prior to Be Completed 24e. Wes en eutopsy performed? peen completion of cause of deeth? cete hes certificete 1 Yes ONN 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certificately filled in by the funeral director, 1 25. Wes case reterred to medicel 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yes No Other: edical Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28e. Date of Injury (Month, Dey Yeer) 27. Menper ot Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours eff To the Funeral Di completely filled in 29a, Certifier Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted. (Check only one) 29b. Signeture and title of certifer 29c. License number 29d. Date signed (Month, Day, Yeer) 30. Name end eddress of person who completed cause of death (frem 23e) (Type, Print)

State Registrar

31. Dete tiled (Month, Day, Year) MAR 0 9 1999 32. Registrar's Signeture

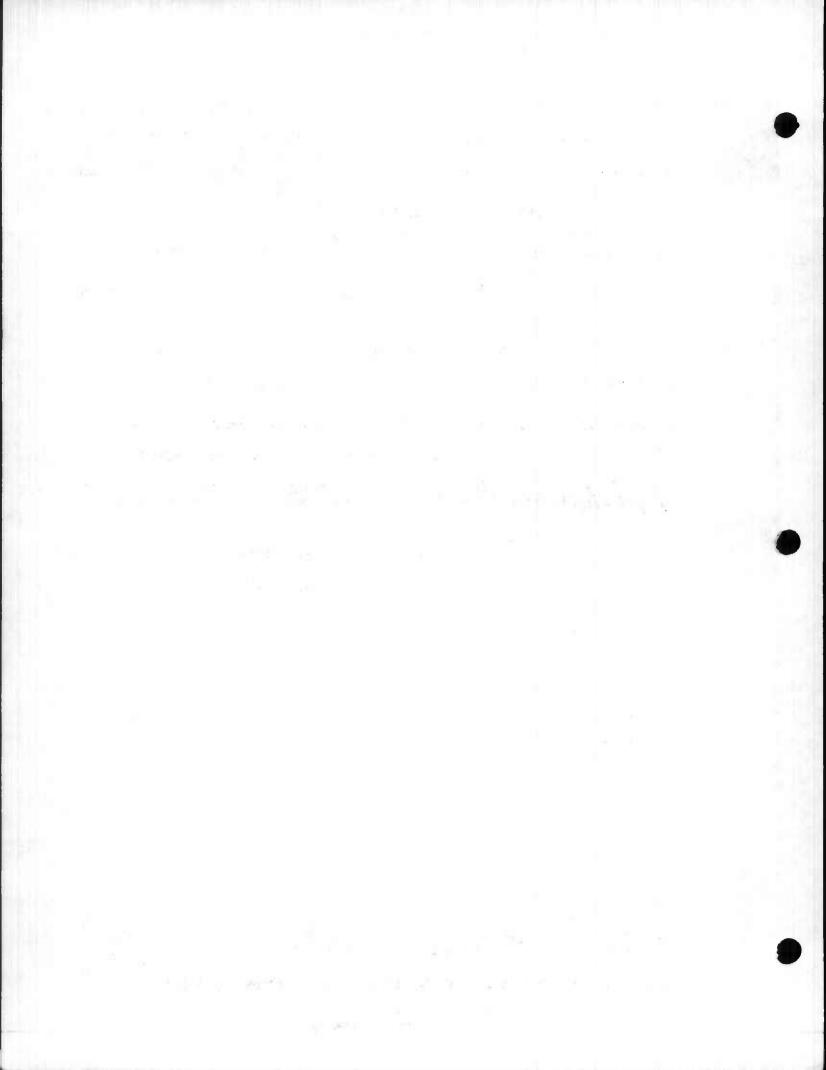
RICHARD A. BURGOYNE, M.D., 607 DUTCHMAN'S LANE, EASTON, MD 21601

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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17	3	1	5	U

Physician	1. Decedent's Nama (First, Middla, Last)  PLIZABETH RES FISHER WEATHERHOLT  2. Date of Death  Month Month March 2 Day 1999												
/Medical Examiner	4a Facility Nama (If not inst MEMORIAL HOS	itution, giva :	street and nu		****		T	4b. City, Town, or CUMBERL	Location of Deal	th 4c. County			
Funeral Director	5. Social Security Number 216–14–1287	6. Sax		7. Age (In yrs 84	. last birthda; Yrs.	y) If Under Months	1 Year Days	If Under 24 Hrs	8. Date of Bi	rth	9. Birth	nplace (Stata or Foreign untry) YLAND	
how	Usual Residence of Dacede 10a. Stata 10b. Co		NY		ity, Town or I							10d. tnsida City Limits 1∭X Yes 2 □ No	
23e or 28e-f	10e. Street and Number 419 FAIRMONT	LANE				10f. ZI <sub>I</sub>	502			10g. Citizen of U.S.		untry?	
ur, or thems cuminer m	11. Marital Status  1 □ Never Married 2 □  3 ☑ Widowed 4 □ Dive	Married	Armed Fo	2X No	U,S. 13	3. Was Dece If Yes, spe 1 Yes		Hispanic Origin? (Sean, Mexican, Puer Specify:	Specify Yes or Note Rican, atc.)	o- 14. Rad Bla Specil	ck, White	ricen Indian, o, etc.	
rygiene. her than "natural", nt, the Medical Ex. Completed by	15. Dec (Specify only I Elementary/Secondary (0		e completed)	) (1-4or 5+)	(Giv	cedent's Usu va kind of wo DO NOT u	ork done se retire	during most of wo	rking	16b. Kind of B		siness/Industry	
rked out	17. Father's Name (First, Mi							ELLA 1	REES	a, Maiden Sumai			
Health and em 27 is me other treum	19a. Informant's Name/Relationship (Type, Print)  F. ALLAN WEATHERHOLT, JR./SON  19b. Malling Address (Street and Number or Rural Route Number, City or Town, Ste  19 W. HIGH STREET, HANCOCK, MD 2175  20a Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - City									750			
Important: if Item 2 any injury or other once.	20a. Method of Disposition 1 ☐ Buriai 2 ☑ Crema 4 ☐ Donation 5 ☐ Oth			State	Place of Dis cametary, cr MBERLA	rematory or	other pla		3/2/99	20c. Location  CUMBER			
ysician Medical aminer	202 GREENE ST., CUMBER  23a. Part 1. Enter the disease, or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or respit shock, or heart failure. List only one cause on each line.  tmmediate Cause (Final disease or condition resulting in death)  a. CORONARY ARTERY DISEASE  Due to (or as a consequence of):									ND, MD	2150	Approximate Interval Between Onset and Death	
use as the buriel-transit	Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underfying Cause (Disease or Injury that initiated avents rasulting in death) Last	<b>{</b>	o		or as a cons								
	Part II. Other significant co	nditions con	ntributing to d	death but not re	sulting In the	e underlying	ceuse gi	iven in Part I.		i tobacco uae co		to the cause of death	
s been sign 2 should be pleted b								1.31		s an autopsy formed?		Were autopsy findings available prior to completion of cause of death?	
elen: artific actor, Be	25. Was case referred to mexaminer?		ha a tha fi						1 = ath (Check only	Yes 2 No		1 Yes 2 No	
T Sign	1   Yes 2   No							rred					
Hospital or 14 hours afta Funeral Dir taly filled in IICal Cert	4 Homicide  4 Homicide  29a. Certifier (Check only 2 Me	ould not be etermined tifying Phys dical Exami	stcian: To the	pasis of examin	cify) nowledge, de	eath occurred	l at the ti	ime, date and plac	City or To	e cause(s) and m	nanner as	stated.	
within 2 To the Complete													

Sunil K. Gupta, M.D.-625 Kent Avenue, Cumberland, MD

32. Registrar's Signature

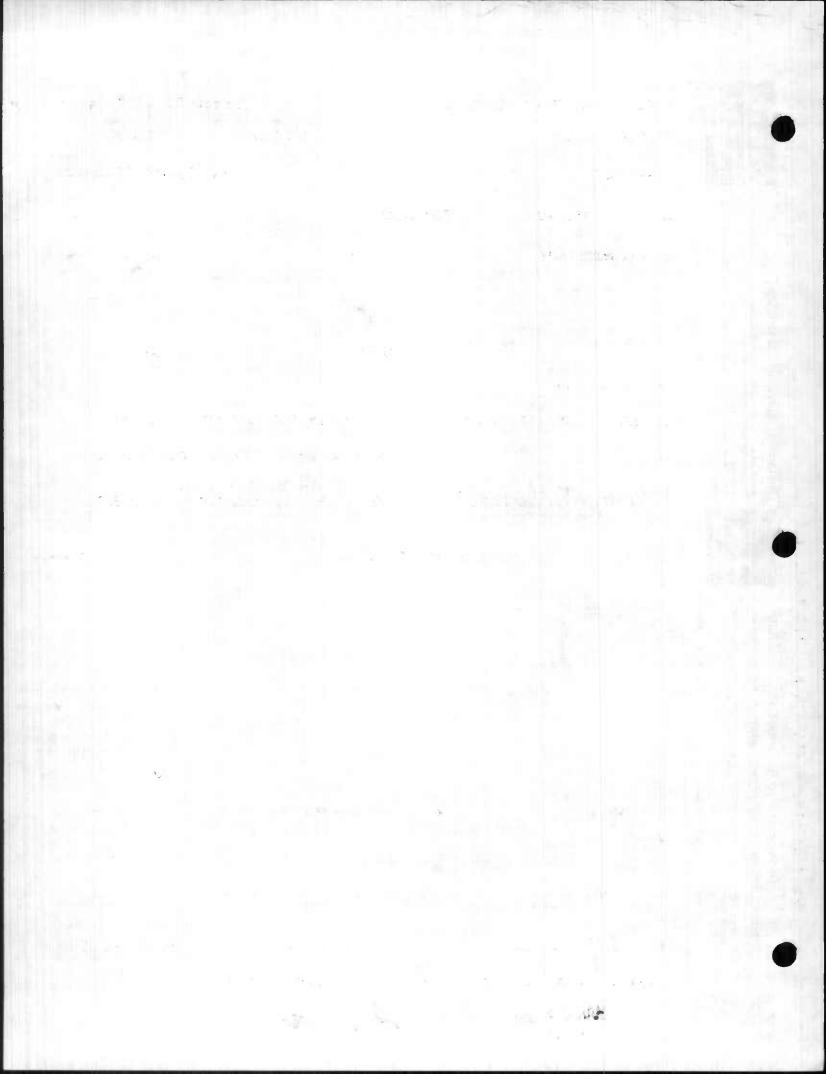
DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 5 1999



State of Maryland / Department of Health and Mental Hygiene 9 9 9 3 4 9

					Certifica	te of	Death	,	Reg. No.		20	2 0
Dharata		1. Decedent'a Name (First, Middle, I	.ast)					2. Date of De	ath	Vens	3. Ti	me of Death
Physic /Medi		Ray L. Warn						Month Februar	Day V	Year 28 1999	2 0	630 am
Exami		4a. Facility Nama (If not institution, g	ive street and number	)			4b. City, Town, or		4	ounty of Death		
		18072 National Plk	е				Long Strete	ch		Garrett		
Funeral Director		5. Social Security Number 6. 212-24-1819	Sex · 7. A	ge (In yrs. last b	Yrs. If Under	Days	r If Under 24 Hrs.				place (S ntry) ykano	tate or Foreign
P.		Usual Residence of Decedent						0.1.1.0				
show	-	10a. State 10b. County		10c. City, Tov	wn or Location					1		de City Limits
Ne W	cto		gany	Frostbu	urg						1	Yes 2 No
hours after death with the Maryland lural', or items 23a or 28a-f show at Examiner must be notified at	Director	10e. Street end Number	National Pike		10f. Z	p Code			10g. Citizer	of What Cou	ntry?	
72 hours after death w "natural", or Items 23a		10072					532-			S.A.		
P C C C C C C C C C C C C C C C C C C C	Funeral	11. Maritai Status	12. Wes Decedent Armed Forces	?	13. Was Deci	edent of ecity Cu	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No o Rican, etc.)	14.	Race - Americ Bleck, White,		an,
8		1 Never Married 2 Married	If Yes Give	No	1□ Yes							
- 4	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:	Korean We	ar	,				Whi	e	
8.8	Completed	15. Decedant's (Specify only highest g	Education rade completed)	168	a. Decedent's Usi (Give kind of w	ork done	upation e during most of wor ed)	king	16b. Kind	of Business/In	dustry	
then the	mpi	Eiamentary/Secondary (0-12)	College (1-4or	,			ed)	25				
		8	0	0	wner/four	ider	100000000000000000000000000000000000000		restau			
la de	Be	17. Father's Nama (First, Middle, Lat	st)				18. Mother's Nar		, Maiden Su	mame)		
th and Mental 7 is marked of traumatic eve	To	Roy Warn					Annie					
00 00 00		19a. Informant's Name/Raiationship	(Type, Print)	19	b. Malling Addras	s (Stree	et and Number or Ru	ıral Routa Numb	er, City or To	own, State, Zip	,	
m 2		William Warn	Son		48 National			Frostburg		Aaryland		532-
if of Her if item or othe		20a. Method of Disposition 1 Buriai 2 ☐ Cremetion 3	☐Removal from State	comet	of Disposition (Na ery, crematory or	other pl	ace)	Date	20c. Locat	ion - City or To	own, Sta	ite
ortant: injury		4 Donation 5 □ Other (Spec			Memorial i	ark		2-Mar-99	Frostb	urg, Mar	ylan	d
Department of H Important: If ite any injury or of once.		21. Signature of Funeral Service Lic	ensee	/	22. Name a	nd Addi	ress of Facility					
25 5 8		John K	A Jures		Durst F	uner	al Home, 57	Frost Ave.	Frostb	urg. MD	2153	2
1900		23a Part Lenter the disease, or co	mplicetions that cause	d the daeth. Do	not enter the mo	de of dy	ring, such as cardiac	or respiratory a	rrest,		Appro	ximate
hysician		rinock, or neart failure. List on	y ona causa on each I	ine.						į	Onset Onset	al Between end Deeth
Medical		Immediate Ceusa (Final	11 - 15	1	1 1	0	0 1			i	18	menths
xaminer		disease or condition resulting in death)	a. Heparty	Meta	stasis	tro	m Colo	n Cano	CLY		10	********
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dansit	Examiner	Sequentially list conditions	b. Adey		consaquence of		Sigmoid	Colon			10	VVC01/C1 4-3
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been signed to should be dated	d by	Diabetes !						24a Was	an autopsy	24b W	ere aut	ppsy findings
noqs	ete	Hypertens	ion						med?	av	railable p	prior to
00 (4)	Completed										death?	
pa	ဒ္							1 🗆 '	Yes 2X	√o 1[	☐ Yes	2□ No
s certificate director, pag	Be	25. Was case raferred to medical examinar?					26. Place of Das	ith (Check only o	one)			
on 0	2	1 ☐ Yes 2 No	Hospital: 1 Inpati		-	UA		ome 5 Resi	denca 6	Other (Special	y)	
ftar this certific ineral director,	:uo	27. Manner of Death  1 Natural 5 □ Panding	28a. Date of Inju (Month, Da		Tima of Injury	28c. Inju	ury at ork?	28d. Describe	how Injury o	ccurrad		
within 24 hours after death.  To the Funerel Director: After completely lilled in by the funer	ati	2 ☐ Accidant Investigati			М	1 [	Yas 2□No					
recto	Ĕ	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide detarmine	d 286. Place of in	jury - At home, f	arm, streat, facto	ry, office		28f. Location ( City or Ton	Street and N	lumber or Run	A Route	Number,
a din	Certification:			ioi (opcony)					, 0,0,0,			
nou ly Fill		29a. Certifiar 12 Certifying F	hyalcian: To the best	of my knowledg	e, death occurred	at the t	time, date and placa	, and dua to tha	causa(s) an	d manner as s	tated.	4.
n 24 Plete	edicai	one) 2 Medical Ex	minar: On the basis of and manner st	r examination at ated.	nd/or investigation	n, in my	opinion, daath occu	rred at the time,	date and pla	ace, and due to	the ca	use(s)
To the Funeral Director: After the completely lilled in by the funeral	Σ	29b. Signeture and title provintifier	^		29	c. Licer	se number		29d. Date s	igned (Month,	Day, Ye	nar)
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ms				,					Ма	rylan	d 2	1536
		Douglas Root	M.U. Gr	antsvi	IIIe CI	ıni	c,P.O. F	30x 610	,Gran	ntsvil	le.	,
Sta	te	31. Data WARDON, Day, Year	Hegist	ars Signatur	- A. 10:10 a.	1			•			,

February 28 1999 66:30 am Roy L. Warn Garrett Long Stretch 18072 National Pike 212-24-1819 69 04-Aug-29 Maryland Frostburg Maryland Allegany 18072 National Pike U.S.A. 21532-White trichectes. Owner/founder 0 Annie Hess Roy Warn 18148 National Pike Frostburg Maryland 21532-William Warn Frostburg Memorial Park 02-Mar-99 Frostburg, Maryland Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Dele of Death Dev Month Year **Physician** Mary E. Wilson 1999 Feb. 24 1:30 p.m. /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, giva street and number) Examiner Cuppett-Weeks Nursing Home 0akland Garrett If Undar 24 Hrs. Hours Min. Birthplace (State or Foreign Country) If Under 1 Yaar 6. Dala of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2X F Months Days Yrs. 235-54-8140 88 Director Aug. 8,1910 West Virginia Usual Rasidence of Decedant the Marylend 10d. Inside City Limits 10a Stala 10b County 10c. City. Town or Location 7 is marked other than "natural", or home 23a or 28a-1 show traumetic event, the Medical Examiner must be notified at 1X Yas 2 □ No Director WV Mineral Keyser 10g. Citizan of What Country? 10e, Street and Number 10f. Zip Coda 500 Carskadon Lane 26726 USA Funerai death 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11. Maritel Status permit. Peges 1 and 2 should be filed within 72 hours effer to Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or hen any injury or other trauments. Bleck, White, atc. 1 ☐ Nevar Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 ♥ No Specify: Specify: PV Year or Datas: 3X Widowed 4 □ Divorced White Completed 15. Decedant's Education (Spacify only highast grada completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Unknown Collaga (1-4or 5+) Homemaker Own Home 18. Mothar's Neme (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middle, Last) Gabriel Evans Bertie Liller 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ratationship (Type, Print) Ronald Evans/Nephew HC 86, Box 125 Fort Ashby, WV 26719 Baltimore, 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Feb. 27 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Crametion 3 ☐ Removat from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 1999 Keyser, WV Potomac Memorial Gardens 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility Rotruck-Smith Funeral Home Brian 85 S. Main Street Keyser, WV 26726 Approximata Intarval Batween Onsat and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediata Causa (Finat l week Influenza disease or condition resulting in death) Examiner Dua to (or as a consaquance of): Examiner physician and the bunal-transit law requires that the death certificete be executed Sequentially list conditions, if eny, laading to Immadiata causa. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of): USB BS 50 the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No signed by ( 3 Probably 4 Unknown 1 Yee Atrial Fibrillation, COPD, Congestive Heart Failure, Records, ð 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed Dementia, Breast Cancer, Hypothyroidism, Hypertension peen page 2 2 No 1 ☐ Yas 2 ☐ No 1 ☐ Yas certificate Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica director. 25. Was casa rafarred to medical 26. Placa of Daath (Check only ona) Be examiner? Othar: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas 2 No P 1 ☐ Inpatiant 2 ☐ ER/OutpatienI 3 ☐ DOA funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Tima of Natural 5 Panding 2 No 1 Yas invasligation 2 Accident 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 Homicida To the Hospital of within 24 hours a To the Funeral D completely filled in 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and mannar stated. 29a Cartifian Medical 29d. Data signad (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2/24/99 D26650

State Registrar

Margaret 31. Dala filad WAR

168

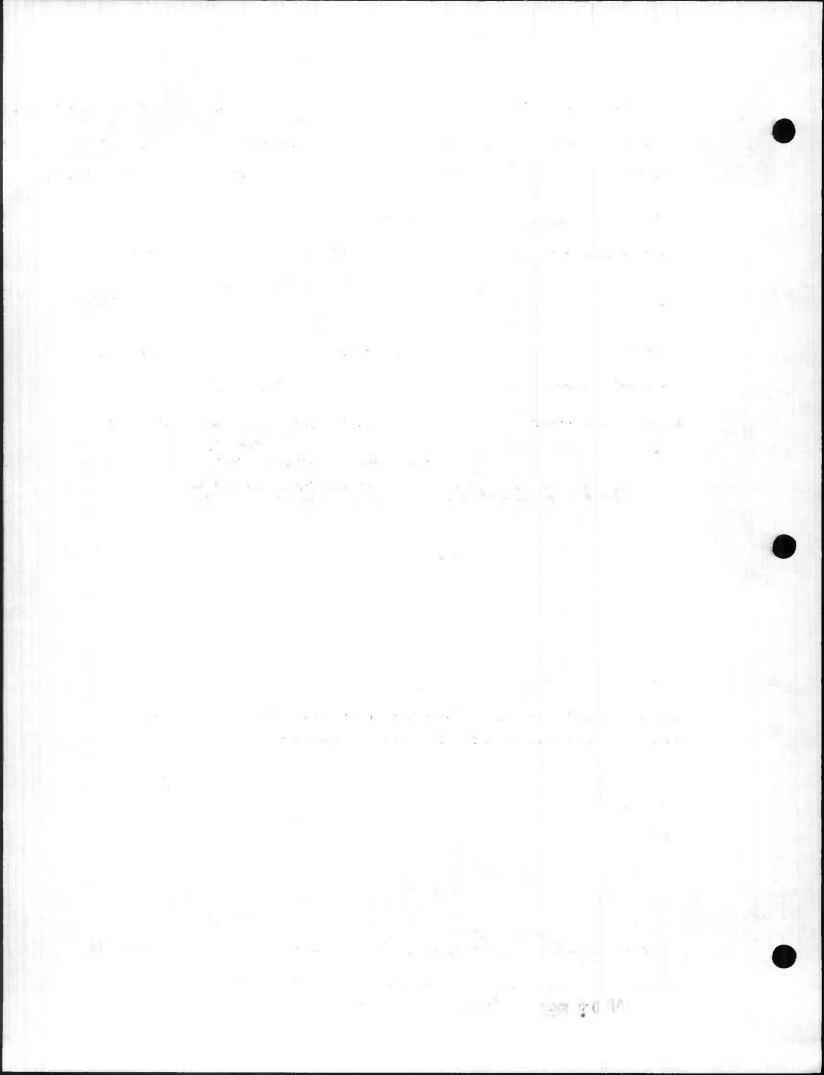
PO Box 486 M.D. 32. agistrer's Signatura

30. Nama and addrass of purson who comptated causa of death (Itam 23a) (Type, Print)

Kaiser,

Manager .

Oakland, MD 21550



State of Maryland / Department of Health and Mental Hygiene 9999995

					Ce	rtificat	e of	Death			Reg. No	).	4	C 2 C 17
Physicia: /Medica	_	1. Decedent's Neme <i>(First, Middle, Willian</i>		Wood	ls		TI	EMPLE	3	2. Dete of De Month March	oeth 07,	y 19	999	3. Time of Death
Examine	_	4e. Fecility Neme (If not institution, 5860 Genesis La		er)					own, or t ederi	ocation of Deef		. County	of Deeth	
Funeral Director		579-36-5576	. Sax 7. 1፟፟፟ 1 M 2☐ F	Age (In yrs. Ie 7		If Under Months	1 Year Deys	If Under Hours	24 Hrs. Min.	6. Date of Bi (Month, De Dec 16	rth ey, Year) ,192	4	9. Birthp Cour Ohio	placa (State or Foreign etry)
r 28a-f show	tor	Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location  Maryland Frederick Frederick								1	0d. Inside City Limits			
8 08 6	ai Director	10e. Street end Number 5860 Genesis La			10f. Zip	Code	2170	)3		-	U.S.	Vhei Cour	ntry?	
urs efter al', or ite	11. Merital Status 12. Was Decedent Ever in U,S. Armed Forcas? 1 Never Merried 2 Married 1 Married 1 Midowed 4 Divorced 1 Married 1 Midowed 1 Divorced 1 Married 1 Midowed 1 Mid							of Hispenic Origin? (Specify Yes or No- luban, Mexican, Puarto Ricen, atc.)					k, White,	en Indien, etc. hite
C 9	15. Decedent's Education (Specify only highast grade completed)  Elementary/Secondery (0-12) College (1-4or 5+) 4  16e. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired) Sales  17. Fethar's Neme (First, Middle, Last)  18. Mother													dustry ng Product
2 should be filed value and Mental Hygie is marked other raumatic event, tr	o Be Co	17. Fethar's Neme (First, Middle, La William	TE	MPLE				er's Nam	e (First, Middle				UNKNOWN	
Pages 1 end ent of Health ht: If item 27 y or other to	0	19e. Informent's Neme/Relationship (Type, Print)  Mr William S. Temple/Son  18504 Samples Manor Dr, Sharpsburg  20e. Method of Disposition  18504 Samples Manor Dr, Sharpsburg  20e. Method of Disposition  18504 Samples Manor Dr, Sharpsburg  20e. Loca cametery, cremetory or other place)  4 Donetion 5 Dother (Specify)  Parklawn Mem Park Mar 11, 1999 Rocks								rg,	land 21782 own, Stete			
pemit. Pa Depertment Important: any injury once.		21. Signature of Funeral Service Lic XXXXIII Service Lice Annual	22. Name and Addrass of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 not enter the mode of dying, such as cardiec or respiretory errest, Approximate intervel Betwee							nd 21701				
Physician /Medical Examiner		Immediate Cause (Finel disease or condition resulting in deeth)		nary	Intervenie.  Due to((or es e consequence of):						Intervel Between Onsat and Daeth			
physicial the burn	edical Examiner	Sequentially list conditions, if eny, leading to immediate ceusa. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in daath) Last	Due to (or a	es e consec	quenca of):									
ending ruse as	MALL		NSION											

Be Completed by Physici

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Cerebrovascular

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA

25. Wes case referred to medical exeminer?

1 Yes 2 No 27. Menner of Death

5 Pending invastigation 2 Accident 3 Suicida 4 Homicide

6 Could not be determined

26e. Dete of Injury (Month, Dey Year) 26b. Tima of

26e. Place of Injury - At home, ferm, street, factory, office building, etc. (Spacify)

26. Piece of Deeth (Check only one)

Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 26d. Describe how injury occurred

24e. Wes en eutopsy performed?

1 Yes

26f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

2 No

29b. Signature and title of certifie

29a. Certifier

Emerone M

29c. Licansa number D36421

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) March 09, 1999

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were eutopsy findings evailable prior to completion of ceuse of deeth?

1 ☐ Yes 2 ☐ No

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

James P. Amerena, M.D., 110 Baughman's Lane, Frederick, Maryland 21702

State Registrar

Certification: To

32. Registrer Signetura

Spark

To the Hospital or Attending within 24 hours effer death.

To the Funeral Director: Aftr completely filled in by the fur

Hospital or Attending Physician: The law requires that the dear

Division of Vital Records, P.O.

and of the same 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev March 2, Doris M. Wallace 1999 . 8:50 p.m. 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 9789 Pearson Road Denton Caroline 5. Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. 9. Birthplece (State or Foreign Country)
Price, MD 8. Date of Birth (Month, Day, Year) June 29, 1 7. Age (In yrs. last birthday) Days 1□ M 2☑ F 71 Yrs. 220-26-3503 Usuel Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No Maryland Caroline Denton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21629 9789 Pearson Road 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 Yes 2√ No Specify: White 3√Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Sacondery (0-12) Collega (1-4or 5+) 11 Hairstylist Cosmetology 17. Fethar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Elwood David Moore Minnie Marie Sipple 19a. Informent's Name/Raletionship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8620 Sherwood Lane, Denton, Maryland 21629 Woody Wallace/Son 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Steta PORBurial 2 ☐ Cremetion 3 ☐ Ramovel from State 4 ☐ Donetion 5 ☐ Other (Specify) Asbury Cemetery/March 7, 1999 Millington, Maryland 21. Signeture of Funeral Service Licensee Fellows, Helfenbein & Newnam Funeral Home, P.A.

PO Box 270, Millington, Maryland 21651-0270

Approximete

Approximete 22. Name and Address of Facility Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition rasulting in deeth) lung concer with Broadwalredon 18 mostles metosta Sequentially list conditions, if eny, laeding to immediate ceuse. Entar Underlying Due to (or as e consequance of): eth? nwor gs

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show adical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours attar c Department of Health and Mental Hygiene. "Important: if Item 27 Is marked other than "natural, or item any Injury or other traumatic event, the Medical Example once."

Baltimore, Maryland 21215-0020

Director

Funeral

Completed by

Be

2

tha Maryland

daath

physician and s tha buriel-trensit To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affar this cartifice complately filled in by the funeral director, t

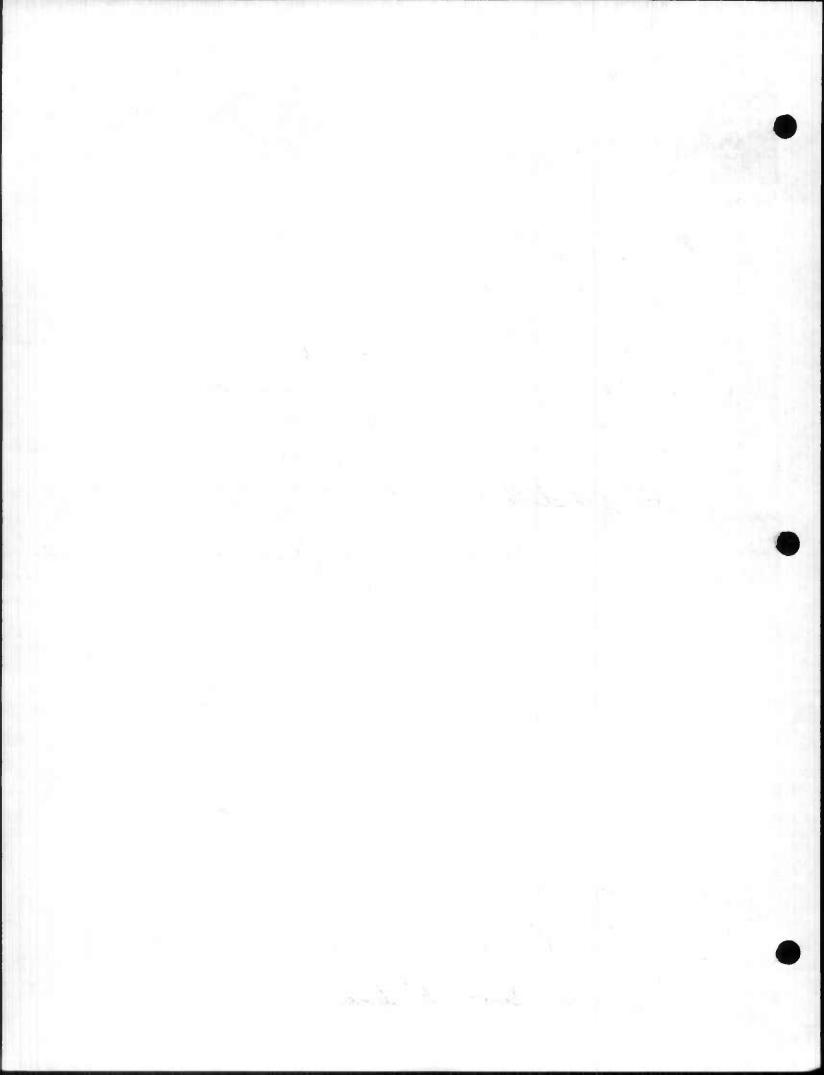
The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Part II. Other eignificant conditions of	ontributing to death but not re-	sulting in the underlyin	g ceuse given in Pert I.	23b. Did tob	acco use co	ontribute to the cause of d		
				24a. Wes en perform	ed?	24b. Wara autopsy findi eveileble prior to completion of caus of deeth?		
25. Wes cesa rafarred to medicel exeminer?			26. Pleca c	of Death (Check only one	)			
1 Yes 22 No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐	ing Home Resider	ome Residence 6 Other (Specify)				
27. Mannar of Death Naturel 5 Pending 2 Accidant investigation	28a. Dete of Injury (Month, Dey Year)	28d. Describe how	28d. Describe how Injury occurred					
3 Sulcide 6 Could not be datarmined	28e. Plece of Injury - At h building, etc. (Space	nome, ferm, street, fect	ory, office	28f. Location (Stre City or Town,	et and Numi Stata)	ber or Rural Route Number,		
29a. Certifier (Check only one)  Certifying Ph 2 Medical Exam	ysician: To the best of my known the common control of the basis of examinating and menner stated.	owledga, daath occurre etion end/or Investigeti	ed at tha time, data end on, In my oplnion, deeth	plece, end dua to the cau occurred et the time, dat	usa(s) and m te end place,	annar as steted. and due to tha ceuse(s)		
29b. Signeture and title of certifier	Along 8	1	29c. License number 7 / 7 8 3 6	: - m d 29	d. Dete signe	(Month, Dey, Yeer)		

Registrar



# Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 3 5 3

ROWAN A. Williams    March 5, 1996	of Death  RUNDEL  9. Birthplece (Stata or Foreign Country)  FLORIDA  10d. Inside City Limits  1 □ Yas 2 X No  That Country?					
Medical Examiner   March   Same (if not institution, give street and number)   4b. City, Town, or Location of Death   4c. County of Same (if not institution, give street and number)   4b. City, Town, or Location of Death   4c. County of Same (if not institution, give street and number)   4b. City, Town, or Location of Death   4c. County of Same (if not institution, give street and number)   4b. City, Town, or Location of Death   4c. County of Same (if not institution, give street and number)   4b. City, Town, or Location of Death   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street and number)   4c. County of Same (if not institution, give street an	of Death  RUNDEL  9. Birthplece (Steta or Foreign Country)  FLORIDA  10d. Inside City Limits  1 Yas 2 No  That Country?  STATES  - American Indien,					
Solution	RUNDEL  9. Birthplace (Stata or Foreign Country)  FLORIDA  10d. Inside City Limits 1 Yas 27 No  That Country?  STATES - American Indien,					
Funeral Director  5. Social Security Number 260-18-2681  6. Sax 10 M 2 F 7. Aga (In yrs. lest birthday) 79 Yrs.  79 Yrs.  6. Sax Months Days Hours Min. 10 M 2 F 10 M	9. Birthplece (Steta or Foreign Country) FLORIDA  10d. Inside City Limits 1 □ Yas 2 No That Country?  STATES - American Indien,					
Director 260-18-2681 JAN. 01, 1920	FLORIDA  10d. Inside City Limits 1  Yas 2 No  That Country?  STATES - American Indien,					
MARYLAND ANNE ARUNDEL ANNAPOLIS  10e. Stele 10b. County 10c. City, Town or Location  MARYLAND ANNE ARUNDEL ANNAPOLIS  10e. Street and Number 10f. Zip Code 10g. Citizen of W  80 3 COXSWAIN WAY #20 7 2140 1 UNITED S  11. Marital Stelus 12. Was Decedent Ever in U.S. Armed Forcas? 12. Was Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexicen, Puarto Rican, etc.)  11. Never Married 2 Merried 3 Welried 3 Wildowed 4 Divorced 10g. Citizen of W  12. Was Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexicen, Puarto Rican, etc.)  14. Race Bleck Specify: Specify:	1 □ Yas 2 1 No  That Country?  STATES  - American Indien,					
MARYLAND ANNE ARUNDEL ANNAPOLIS  10e. Street and Number  80 3 COXSWAIN WAY #20 7  11. Marital Stetus 1	hat Country?  STATES  - American Indien,					
803 COXSWAIN WAY #207  11. Marital Stetus 1 Never Married 2 M Merried 3 Widowed 4 Divorced  10. 2 1401  11. Was Decedent Ever in U.S. Armed Forcas? 1 M Yes, Sive 1 M Yes, Give Yes or No-Bleck WWTT  1 Yes, Sive 1 No Specify: 1 Yes, Specify: 1 Yes, Specify:	STATES - American Indien,					
SUS COXSWAIN WAY #ZU7   21401   UNITED States   1. Marital Stetus   1. Marital Stetu	- American Indien,					
Armed Forcas?  1 Never Married 2 Merried 1 Never Married 2 Merried 1 Never Married 2 No HYes, Give 1 No Specify:  3 Widowed 4 Divorced Yaer or Detes: WWTT						
	WHITE					
3 Wildowed 4 Divorced Year or Detes: WWII  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  15. Decedent's Education (Give kind of work done during most of working life. Do NOT use retired)  12  16b. Kind of Bus (life. Do NOT use retired)  17  18  19  19  10  10  10  10  10  10  10  10	sinass/Industry					
(Specify only highest grade completed)  (Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use refired)  (Give kind of work done during most of working life. DO NOT use refired)						
Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ PROFESSOR U.S. NAV 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme	VAL ACADEMY					
12 5+ FROFESSOR U.S., NAY 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme	Mother's Name (First, Middla, Maiden Sumeme)					
JOHN K. WILLIAMS  ETHEL ANTHONY  19e. Informent's Name/Reletionship (Type, Print)  19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, S						
CENT INTERESTRICT (WILL)	MD . Z1401 City or Town, Stete					
cemetery, cremetory or other place) 03-09-99	VILLE, MD.					
12 Buriel 2   Cremetion 3   Removel from Stala   4   Donetion 5   Other (Specify)   MARYLAND VETERANS CEMETERY   CROWNST   22. Name end Address of Fecility   JOHN M. TAYLOR FUR						
147 DUKE OF GLOUCESTER ST. ANNAPOI	LIS, MD. 21401 Approximete					
23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.	Intervel Between Onset end Death					
Physician  /Medical Immedieta Cause (Fine)	SEVERAL					
Examiner disease or condition resulting In death)  e. CONSESTIVE TEAT PAILURE	YEARS					
Due to (or as e consequenca of):						
Due to (or es e consequenca of):  Sequentially list conditions, if eny, leeding to immediate cause. Enter Indexiving	i					
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest  b. Due to (or es e consequenca of):  c. Due to (or as a consequence of):						
Couse. Enler Underlying Couse (Disease or Injury thet initiated events resulting in deeth) Lest  Dua to (or as a consequence of):						
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use con	stribute to the cause of death?					
d	3 Probably 4 Unknow					
Dear II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Pert I.  24e. Wes en autopsy performed?	24b. Ware eutopsy findings availeble prior lo					
24e. Wes en autopsy performed?  1  Yes 2 No  25. Was case referred to medical exeminer?  25. Was case referred to medical exeminer?  26. Plece of Death (Check only one)	completion of cause of deeth?					
1 yes 2 No	1 ☐ Yaa 2 ☐ No					
25. Was case referred to medical exeminer?  26. Plece of Death (Check only one)  27. Wenner of Deeth  28. Dete of Injury	er (Specify)					
1 U Yes 22No 1 Delingatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Rasidanca 6 Dothe 27. Menner of Deeth 28. Dete of Injury 28b. Time of Injury Work? 28d. Describe how injury occurre Work?						
1) Neturel 5 Pending (Month, Dey Year) Injury Work? 2 Accident investigation M 1 Yes 2 No						
2 5 5 5 3 Suicida 6 Could not be 28e. Place of Injury - At home, farm, streat, factory, office 28f. Location (Street and Number	er or Rural Routa Number,					
building, etc. (Specify)						
29a. Certifier  (Check only)  29a. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mer course of the time, date and place, and due to the cause(s) and mer course of the time, date and place, and due to the cause(s) and mer course of the time, date and place, and due to the cause(s) and mer course of the time, date and place, and due to the cause(s) and mer course of the time, date and place, and due to the cause(s) and mer course of the time, date and place, and due to the cause(s) and mer course of the time, date and place, and due to the cause(s) and mer course of the time, date and place, and due to the cause(s) and mer course of the time, date and place of the time.						
end menner stated.  29b. Signeture end title of certifier 29c. License number 29d. Date signed	i (Month, Day, Year)					
Land State of the	0.6					
14hort Sett Edin, MD \$30701 3/5/	79					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)	1/ 000					
ROBERT SCOTT EDEN, M.D. 600 RIDGELY AVE, ANNAPOLIS, MD 2	170					
State  State  31. Dete filed (Month, Day, Year)  32. Registrar's Signeture						

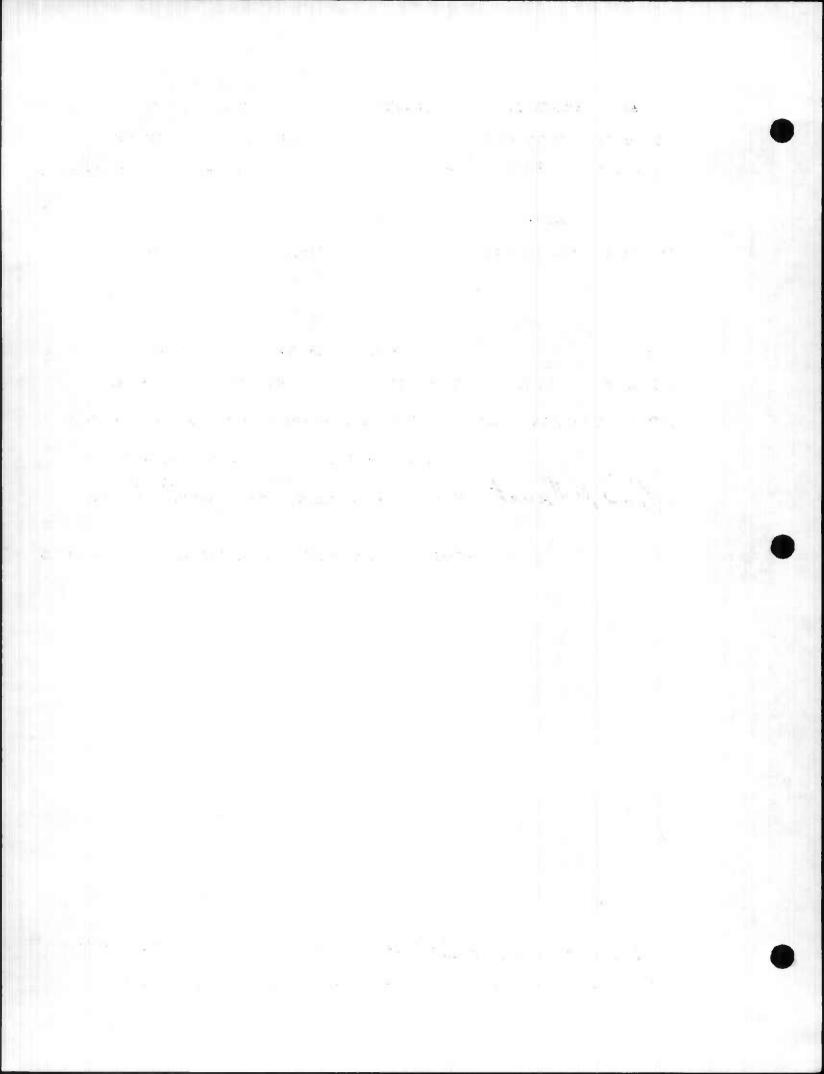
PPPT ILA SUR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 0 9 3 5 4

				Certific	cate of	Death			Reg. No.				
	me (First, Middla, Las	it)						ata of Dea	ath Day	Year	3. Tim	a of Deeth	
ician dical ROY	FREDE	RICK	WINK	ELVOSS				RCH 2			4:	00 AM	
	(If not institution, give	street and number)				4b. City, Town	n, or Location	n of Death	4c. Cou	nty of Deeth			
2332 PA	RADISE POI	NT ROAD				OAKL			GAI	RRETT			
5. Social Sacurity 193-03-	1985	ax 7. Aga XIM 2□ F	(In yrs. last t		Indar 1 Yaar hths Days	If Undar 24 Hours	Min. (A	ata of Birt Month, Day G 6,	y, Year) 1916	Cou	olaca (Stantry) SYLV	ANIA	
Usual Rasidance 10a. Stata	10b. County		10c. City, To	wn or Location	)						lOd. Insid	a City Limits	
MD MD	GARR	ETT		OAKLAN								Yas 20 No	
MD  10e. Street end N  2332 PA  11. Marital Status  1 Navar Ma	umber RADISE POI	NT ROAD				21550				SA			
3 ☐ Widowed	rried 2 Married	12. Was Decedant E Armed Forcas? 1 ☐ Yas 2 ☑ N If Yas, Giva Yeer or Detes:			Decedant of I specify Cub as 2 X No	dispenic Origin an, Mexican, F Specify:	n? (Specify ) Puarto Ricar	res or No n, atc.)	E	14. Raca - Amarican Indian, Bleck, White, etc.  Specify: WHITE		n,	
(Sp Eiamantary/Se 12	15. Decedant's Ed		16	a. Decedent's (Giva kind	Usual Occup of work dona OT use retire	during most or	f working		16b. Kind of	f Businass/In	dustry		
Eiamantary/Se	condary (0-12)	Collaga (1-4or 5	+)			ERATOR			STEE	L MILL			
17. Fathar's Name	a (First, Middla, Last)					18. Mothar's	Nama (Firs	it, Middla,	Maiden Sum	ama)			
FREDERI	CK (n	mi)	WINKE	LVOSS		EL	IZABE	TH	KERBER				
	Name/Ralationship (7	ype, Print)	15	9b. Mailing Add	drass (Straat	and Number	or Aural Aou	ıta Numbe	r, City or Town, Stata, Zip Coda)				
PHYLLIS	WINKELVOS	SS - WIFE				E POINT					MD 21550		
	sposition  Cramation 3   5 Othar (Specify		cama	of Disposition tary, cramators A CREM	or othar pla	ca)	3/8/				WN, WV		
21. Signature of	JUL	4	00167			ass of Facility  VERAL H	IOME -		BOX 2		50		
23e. Pert1. Enter shock, or he	the disease, or comp ent feilure. List only o	olications thet caused	the daath. De	o not enter tha	moda of dyi	ng, such as ca	ardiac or ras	piratory e	rrest,	1		Between	
n Immediate Ceus	(Finat									1	Unsat a	and Death	
disaasa or condit	mmediate Ceusa (Finat isaasa or condition esulting in death)  e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE MINUTES  Due to (or es e consequence of):												
<b>1</b> 5	Due to (or es e consequence of):												
Sequantially list of fery, leading to Causa. Enter Un	conditions, immadiate darlying	b	ua to (or as a consequance of):										
Causa (Diseesa that initiated avar rasulting in daath	ILS	C	Dua to (or as a	a consaquance	of):								
		d											
Pert II. Other sign	ificent conditions co	ontributing to death bu	it not rasulting	in tha undarly	ring causa gi	van in Pert I.		23b. Dld	tobacco use	contribute t	o the car	use of death?	
								1 🗆	Yee 2□N	o 3 Pro	bably	4∑ Unknown	
ped by									an eutopsy		ara euto	psy findings	
Completed								perio	rmed?	C		of cause	
Eo								1 🗆 '	Yes 2X No	D 1	☐ Yas	2 No	
25. Was casa raf	arred to medical					26. Plece of	of Deeth (Ch	eck only o	one)				
1 Yes 2	] NO	Hospital: 1 Inpatia	nt 2 ER/	Outpatient 3[	1 DOA		ing Homa	5 🕅 Rasi	dance 6 🗆	Othar (Speci	ity)		
27. Mennar of Da 1 Neturel 2 Accident	eth 5 ☐ Panding invastigation	28a. Data of Injur (Month, Day	Year) 28b	Tima of Injury	28c. Inju Wo	ryat irk? ]Yas 2∐ No		Describe	how Injury oo	curred			
	3 Sulcide 6 Could not be determined 28e. Piece of Injury - At homa, farm, streat, fectory, offica building, atc. (Spacify) 28f. Location (Stractive City or Town,									imber or Rui	al Routa	Number,	
29a. Cartifiar (Check only one)		valcien: To the best of liner: On the basis of end menner sta	axaminetion a									use(s)	
29b. Signature er	d titla of certifiar				29c. Lican	sa number			29d. Data sig	gned (Month	Day, Ye	ar)	
Pa 30 Name and ad	ul Das	wer & n	uth (Item 222	(Type Print)	Н2615	54			MARCH	1 3, 1	999		
	drass of person who o NIEL MILLE				ACRES	S DRIVE	OAK	LAND	, MD 2	1550			
State 31. Data filed (Mg			r's Signeture	J HOLL	HORES	DILLI	. OIM		, 2.				

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM: #5 PER F.H. G770 4-14-99 WR. Amend #23 partl 3/18/99, BMW, Montg. Cty perM.D. Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Daath 3. Time of Death **Physician** YENIKOMSHIAN LEON AGHEK MARCH 9, 1999 4:35 P.M. /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4515 WILLARD AVENUE #2003 S CHEVY CHASE MONTGOMERY 5. Social Sacurity Number 7. Age (In vrs. last birthday) If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (Steta or Foraign Country) **Funeral** Days 1**X** M 2□ F Months Hours 577-06-8195 Director DEC. 31, 1902 KILLIS TURKEY Usual Residence of Decedent the Meryland 10a. Stata 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examples must be notified at 10b. County 10d. Inside City Limits 1 Yas 2 No Director MONTGOMERY CHEVY CHASE 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? with 4515 WILLARD AVENUE #2003S 20815 U.S.A. Funeral death 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Dacadant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 🏋 No If Yas, Give 14. Raca - Amarican Indian, Black White atc. efter 1 Navar Marriad 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: Specify WHITE 2 3 Widowad 4 Divorced Yaar or Datas Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Dacedent's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) Collaga (1-4or 5+) RADIOLOGY PHYSICIAN/MEDICINE marked other v permit. Pages 1 and 2 should be file Depertment of Health and Mentel Hy Important: If Item 27 is marked othe any Injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumema) 17. Fethar's Nema (First, Middla, Last) AGHEK YENIKOMSHIAN MARIA SEROPIAN 19a Informent's Nama/Ralationship (Type Print) 19b. Mailing Addrass (Straet end Number or Rurel Route Number, City or Town, Stete, Zip Code) ADRINE YENIKOSHIAN 4515 WILLARD AVE. #2003S, CHEVY CHASE, MD 20815 WIFE 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of 20c. Location - City or Town, Stata cametary, crematory or othar placa) 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from State GATE OF HEAVEN CEMETERY 4 ☐ Donation 5 ☐ Othar (Specify) 3/13/99 SILVER SPRING, MD 21. Signati JOSEPH GAWLER SONS, INC. 5130 WISCONSIN AVENUE of Fungral Service Licenses NW, WASHINGTON, DC 20016 inclications that caused tha daath. Do not entar the moda of dying, such as cardiac or raspiratory arrast Approximata Intarval Batween Onset and Death **Physician** /Medical Immediate Cause (Final Sweek diseasa or condition resulting in death) Examiner Examiner 10 YEARS law requires that the death certificate be executed Saquantially list conditions, if any, laading to immadiate causa. Entar Underlying Causa (Disaasa or Injury that initiated events resulting in daath) Last end the buriel 104EALS physician Box 68760. CHILL Physician/Medical Dua to (or es e consequence of) 60 ettending | P.O. Part II. Other significent conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? the th a signed by the 2 No 3 Probably 4 Unknown 1 Yes Records, p 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy Completed peed hes le 2 page The 1 Yas 2 No certificate 1 TYas 2 No. Division of Vital l or Attending Physician: efter deeth. director, Be 25. Was casa rafarred to madical axaminer? 26. Placa of Daeth (Check only one) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Spacity) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28e. Dete of Injury (Month, Day Yaar) 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? After Natural 5 Panding investigation in 24 hours ener committee the Funeral Director: Africately filled in by the fu 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicide Hospital 29a. Certifier 1 Certifying Phyeicien: To the best of my knowladga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stetad.

2 Medical Examiner: On the basis of axemination end/or investigation, in my opinion, deeth occurred et the time, date end place, end dua to the causa(s) and mannar statad. edical (Check only To the vithin 2 29c. Licanse number 29b. Signature and fittle of certified 29d. Data signed (Month, Dev. Year)

D33554

5401 WESTERN AVENUE, NW, WASHINGTON, D.C. 20015

sa of daath (Itam 23a) (Type, Print)

32. Ragistrar's Signature

MARCH 10, 1999

State Registrar 30 Name and address of person

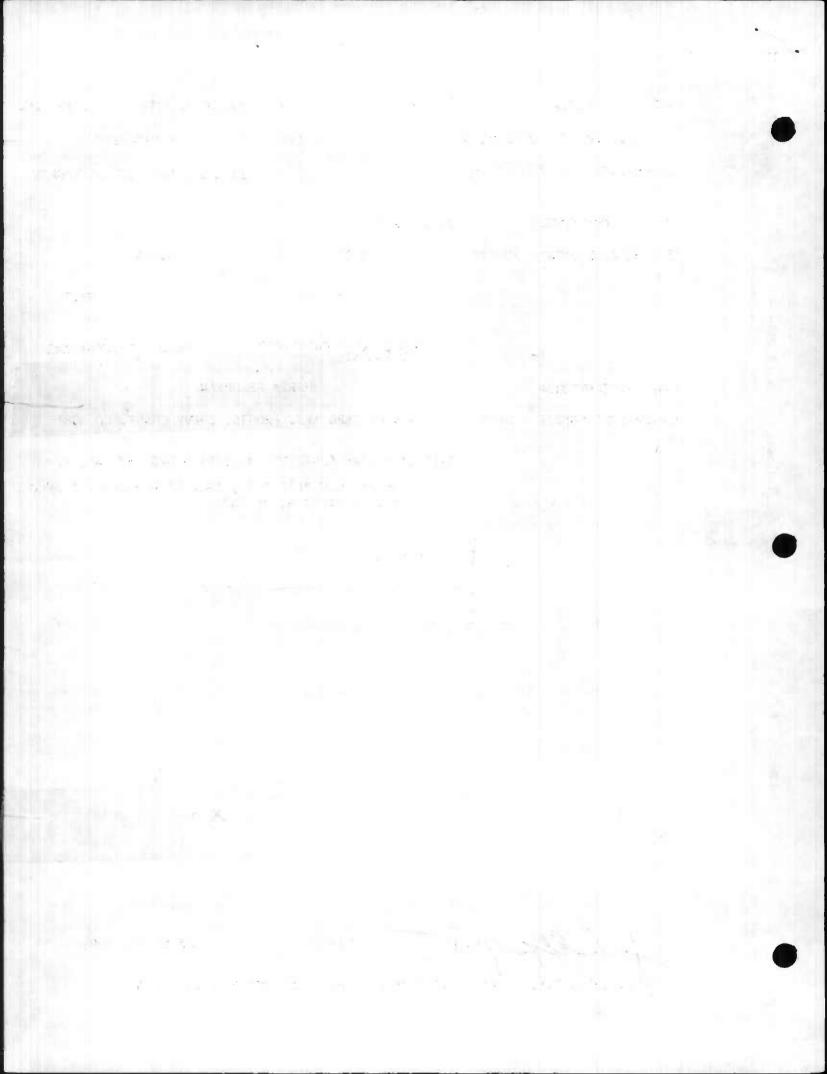
JOHN E. YERG

31. Date filed (Month, Day, Yaar) MAR 12

who d

M/D.

1999



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death

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	Physicia	_	1. Decedant's Nama (First, Middla, Last)  JEFF _ YOUNG  2. Data of Deeth Month Day Year											
	/Medic Examin	_	4a Facility Nama (If			)	IABILIT	ATION	4b. City, Town, or MONTGOMEI		th 4c. County		2:45 AM	
l	Funeral Director		5. Social Sacurity Nu 218 30 25		_/ _	ga (In yrs. la 70	rst birthdey) Yrs.	If Under 1 Y	eer If Under 24 Hrs ays Hours Min		irth Year) ,1928	9. Birth	placa (Steta or Foraigi ntn) GINIA	
	Aaryland f show ed at	or	Usuel Rasidance of I 10a. State MD.	Decedant 10b. County MONTGOM	ERY	10c. City	Town or Loc		WOOD				10d. Insida City Limits	
		Director	10e. Street and Num 7345 M		MILL ROA	D		10f. Zip Co	da 20855		10g. Citizen of V			
020	urs efter	by Funeral	11. Maritet Status  1 Never Marrie 3 Widowed 4	d 2 Married	12. Wes Decedent Armed Forcas' 1  Yes 2 If Yas, Giva Yaar or Datas:	Ever in U,S		es Decedant Yas, specify	of Hispanic Orlgin? (S Cuban, Mexican, Puar	Specify Yes or No- to Rican, atc.) 14. Ra BI Spec		e - Ameri ck, White,	can Indian,	
21215-0020	d within 72 jene. r than "nat r a Medic	Completed	(Specification (Specification)	15. Decedant's Ed y only highast grad dary (0-12)	College (1-Aor 5+) life. DO			O NOT usa r	ocupation fona during most of wo atired) MENT OPERA		16b. Kind of B			
Maryland	id be fill ental H ked off	To Be (	17. Fathar's Nama (F JIM			18. Mothar's Na MINNIE		a, Maiden Suman VESAY	na)					
	of Heelt f frem 2 r other		20a. Mathod of Dispo	UNG, DAU		Ce	104 No	ORTH T	r place)	, MT. AI	RY MD	2177 City or T	1 own, Stata	
Baltimore	pemit. Peg Department Important: it any injury o		21. Signatura of Fun	will disassa, or comp	H- Ba	rher	M	Nama and A	ddrass of Fecility H. BARBER 5038, LAY f dying, such as cardia		HOME		2 Approximate	
	Physician /Medical Examiner	16	snock, or naero Immediata Causa (F disaasa or condition rasulting In daath)	inal	a.	Due to (or	as e consequ					1	Interval Between Onsat end Death  4 was  One year	
x 68760,		cian/Medicai Examiner	Sequentially list con- if any, leading to imr- cause. Enter Under Causa (Disease or in that initiated evants resulting in death) Le		bc.	Dua to (or	es a consaques es e consequ	enca of):	a accid	lent		1	oneyeas	
P.O. Box	0 0 0	Physi	Part II. Othar signific	cant conditions co	entributing to death t	but not rasu	iting in tha un	darlying caus	se givan in Pert I.		d tobacco use co ] Yes 2□ No	ntributa (	to the cause of death	
Records,	8 5 2	Completed by									es en eutopsy formed?	a	Vare autopsy tindings vallabla prior to ompletion of cause f deeth?	
tal R	iclan: The li certificate he rector, page	60	25. Was casa refarre	ad to medical					26 Place of De	ath (Check only	Yes 2 No	1	☐ Yes 2 No	
of Vital	5 00	ToB	axaminar? 1 ☐ Yas 2		Hospital:	ient 2 🗆 E	R/Outpatient	3□ DOA	Othor		sidanca 6 □Ott	ar (Spec	ify)	
	After the		27. Mannar of Death 1 ☐Natural 2 ☐ Accidant	5 Panding invastigation		ury ay Year)	28b. Tima of Injury	28c.	Injury at Work? 1  Yas 2 No	28d. Describe	how injury occur	red		
Division	or Atte	Certification:	3 ☐ Suicida 4 ☐ Homicida	6 ☐ Could not be daterminad	28a. Place of in	ijury - At hor tc. (Spacify,		at, factory, o	ffica	28f. Location City or T	(Street and Numbers)	ber or Rui	ral Route Number,	
	Hospi 24 hour Funer tely fil	edicai				of exeminati			he time, date end plac my optnion, deeth occ					
	To the To the comple	-	29b. Signatura and ti	itle of cartifier	>			29c. L	icansa number		29d. Data signe	d (Month	, Day, Year)	

Registrar

31. Data filed (Month, Day, Yaar) MAR 0 9 1999 32. Registrar's Signeture

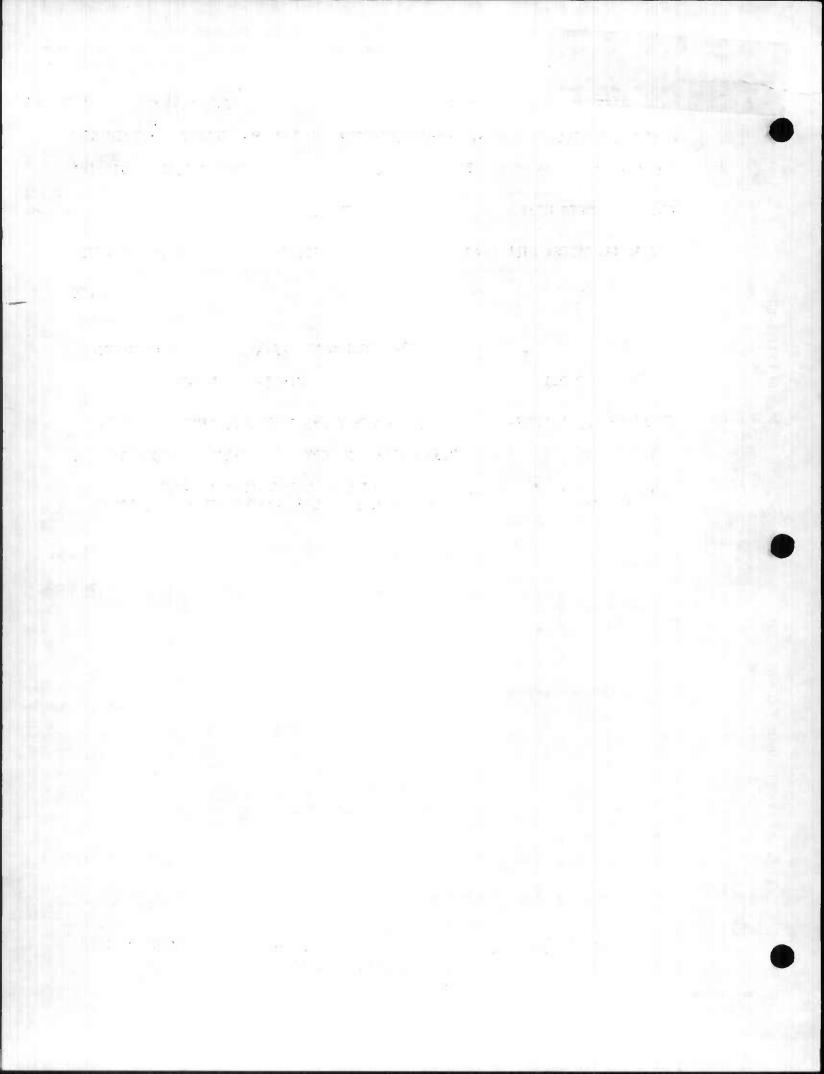
mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan R. Pollack, m.D.

809 V. ess M.71 Rd Rock ville, md 20851

D 33 443

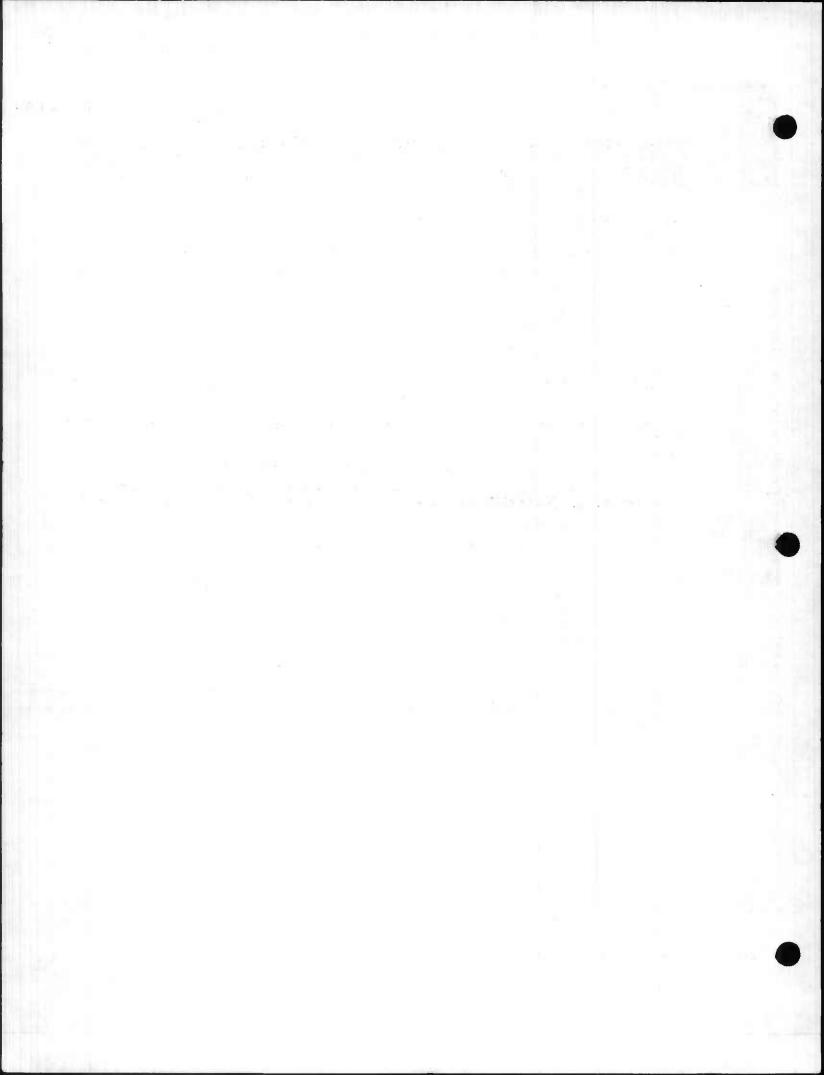
29d. Data signed (Month, Day, Year) MARCH 8, 1999



State of Maryland / Department of Health and Mental Hygiene

Physic /Med Exami		Decedent's Neme (First, Middle, La	ist)				2. Dete of Deet	h	3. Ti		
/Med							Month	Dey	Veer	me of Death	
Exam	icai	Anne E.					MARCH			130 P.N	
	iner	4e. Fecility Neme (If not institution, giv				4b. City, Town, or Lo		4c. County			
		Shady Grove Ad  5. Sociel Security Number 6. S		(In yrs. last bi		Rockvill or   If Under 24 Hrs.			gomery	_	
Funera Director			IDM 2DE	98	Yrs. Months Dey	s Hours Min.	8. Dete of Birth (Month, Day, January	Year) 18, 19	9. Birthplece (S Country) 01 Po1		
yland		10e. Stete 10b. County 10c. City, Town or Location							10d. Ins	Ide City Limits	
Mar Mar	tor	Md Montgom	ery	Potomac			XX.			Yes 2□ No	
or 28	Oire.	10e. Street end Number			10f. Zip Code			10g. Citizen of Whet Country?			
th will	a	11 Brooke Crest	Court	20854				U.S.A	. •		
hours after death with the Maryland ural; or items 23s or 28s-f show at Examiner must be notified at	by Funeral Director	11. Maritel Status  1 Never Married 2 Married  3XXWidowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give XX Yeer or Dates:		Wes Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuben, Mexican, Puerto Rican, etc.     □ Yes 2□ No Specify:			14. Race - American Indien, Bleck, White, etc.  Specify: White		en,	
72 hours "natural",	ted	15. Decadent's E	ducation	16e	. Decedent's Usuel Occ	upetion	1	16b. Kind of Bu	siness/Industry		
within 7 ene. than "n	Completed	(Specify only highest green Elementery/Secondery (0-12)		+)	(Give kind of work don life. DO NOT use reti	e during most of workli red)	ng				
THE REAL PROPERTY.	Con		College (1-4or 5- 2 Years		Housewife			Own Home			
0 = 0 5	Be	17. Fether's Neme (First, Middle, Last, Morris Eisenber				18. Mother's Neme			9)		
should by and Menta	To Be						Horowit				
0 0 0 0		19e. Informent's Name/Reletionship (			. Meiling Address (Stre						
Heal Ther		Theodore Yaffe-	Son		Brooke Cre f Disposition (Name of	est Court,			and 208.		
Peges nent of I int: If Ite		XIX Kuriel 2 Cremetion 3		camete	ry, cremetory or other p	lece)	Date	LOC. LOCATION - C	only or rown, on	7.6	
it. P		4 ☐ Donetion 5 ☐ Other (Specification 21. Signeture of Funeral Service Licer		Lakes	ide Memoria		999 M	iami, F	lorida		
permit. Peges Department of Important: If Its any Injury or o		Monald (.)	Stottlem	yer	Danzansky 1170 Rock	-Goldberg wille Pike	, Rockv	ille, M	ls, Incaryland	20852	
		23a. Pert1. Enter the disease, or com shock, or heart feilure. List only	plicetions that caused one cause on each li	deeth. Do	not enter the mode of d	ying, such es cerdiac o	r respiretory erre	est,	Interv	ximete el Between	
Physician	_	1-000							Onset	end Death	
/Medical Examiner	_	Immediate Ceuse (Finet disease or condition resulting in death)	· mues	10 gro	en syst	emful	are			DAY	
	5	Tooling in doding	1 - 8	ue to (ocas a	consequenca of):  Myocara	0500 10	1200	Ten	2	DAYC	
hed	Ē		D			eca n	yana	con		-/1-	
ificate be executed g physician end es the burial-transit	Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	80-	ue to (or as e	consequence of):				2	DAYS	
a be	edicai	Cause (Diseese or injury that initiated events	0.	270	consequence of:						
g phy es th		resulting in death) Last									
	M/UE		d								
deat he ett	sicia	Pert II. Other significant conditions of	given in Pert I.	23b. Did tobecco use contribute to the cause of death?							
as that the death cer igned by the ettendir be detached for use	Physician/M	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23t						1 Yes 2 No 3 Probably 4 Unknown			
as the gned be de	by 8										
requir seen s hould	Completed			246				e. Wes en eutopsy performed? 24b. Were eutoeveileble completio of deeth?		prior to in of ceuse	
The I	E O						1□ Ye	s 2 No	1 ☐ Yes	2 No	
	Be (	25. Wes case referred to medical exeminer?				26. Plece of Deeth	(Check only one	a)			
2 0 0	10	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ N					rsing Home 5 Residenca 6 Other (Specify)				
ding P. After t	on:	27. Manner of Death  1 ☑ Naturel 5 ☐ Pending	28e. Dete of Injury (Month, Dey		1-7	ury at 2 ork?	28d. Describe ho	w Injury occurre	bed		
Attending or death.	cati	2 Accident investigation 3 Suicide 6 Could not b	e -			Yes 2 No					
는 의 마이	Certification:	4 Homicide determined	28e. Plece of Injurbuilding, etc.		ırm, street, fectory, offic	9 2	28f. Location (Str City or Town,	eet end Numbe , Stete)	er or Rural Route	Number,	
To the Hospital or within 24 hours effu To the Funeral Dir completely filled in	edical	(Check only 2 Medical Exam	niner: On the basis of a	exemination en	e, deeth occurred et the d/or investigation, in my	time, date and pleca, e	end due to the ce	use(s) and mar	nner es stated. nd due to the ce	use(s)	
thin 2 the I	Med	one)	and menner stet	ed.		nse number					
F ₹ F 8	-	29b. Signature end title of pertified	Horaci						(Month, Dey, Yo		
2		ye an	nich car	VE CON	sultant		/,	MICH	04 (	77/	
		30. Name end eddress of person who		eth (Item 23a)	(Type, Print)		00 25	PHET DI	1 844 3	12817	
		URPUDRA K-SA	XENA MY	7//1	DUNG / MA	SING CLAN	121, 150	19 6302	1 /200	0 0	

DHMH 16 Rev 6/95



**Physician** /Medical Examiner ician end burial-transit The lew requires that the death certificate be executed P.O. Box 68760,

**Physician** 

/Medical

Examiner

10e. State

**Funeral** 

Director

28a-f show

6 items 23s

permit. Peges 1 end 2 should be filed within 72 hours effer to Department of Health and Meriel Hygiene.
Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinations.

Baltimore, Maryland 21215-0020

Examiner mant be notified at

Director

Funeral

þ

Completed

Be

the Marylend

physician s the burial signed by the Hospital or Attending Physician: this After To the Hospital within 24 hours efter deeth.
To the Funeral Director: After normalately filled in by the fu

Records,

Division of Vital

Examiner Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Physician/Medical Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. þ Completed 25. Wes cese referred to medical examiner? Be 1 Yes 2 No Certification: To 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier Medical (Check only

State Registrar THEODORG I GWEBE 31. Dete filed (Month, Day, Year)

MAR 1

29b. Signature and title of certifier

32. Registrer's Signature

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

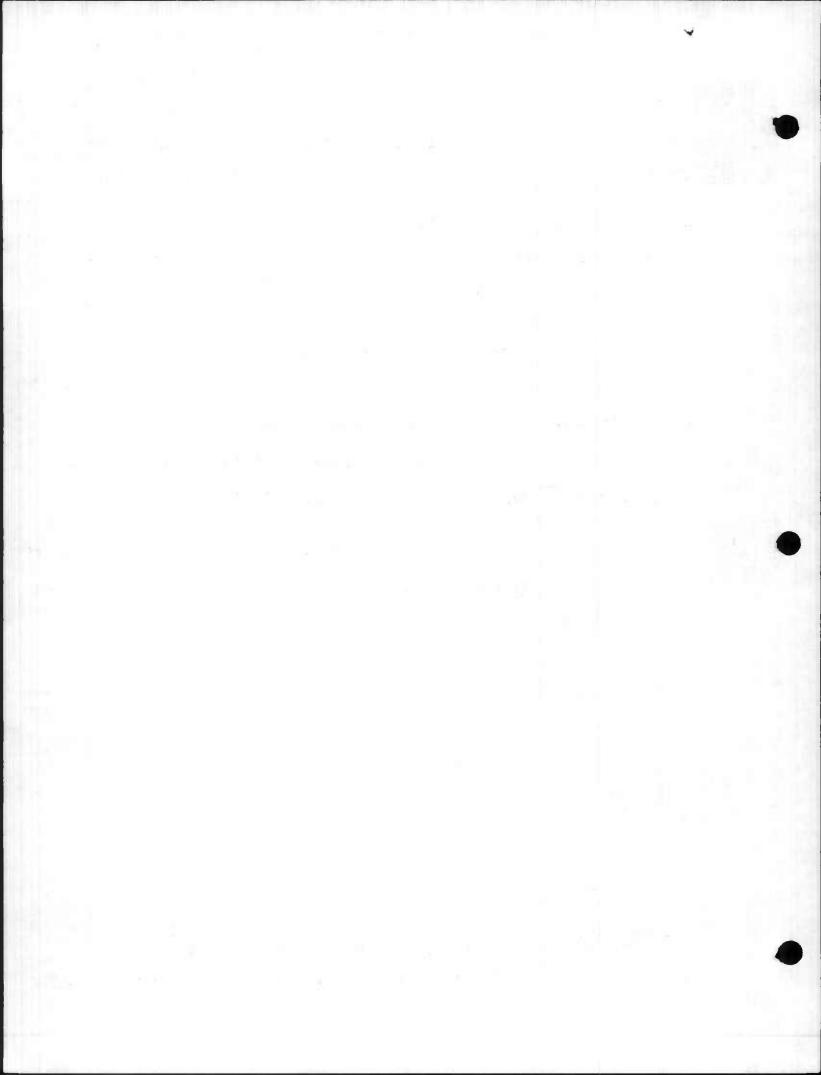
29c. License number

DD52927

8910 MEDICAL DRIVE GAITHERSBURG MD 20816

29d. Dete signed (Month, Dey, Year)

MARCH 06.1999



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Decedent's Nam	na ( <i>FIIST, MIODI</i> a,	Listy					2. Date of Di		Verr	3. Time of Deat		
hysician	JULIA REVELLE YOUNG							MARCH	6 Day 199	9 Year	3:50A		
/Medical examiner	4e Facility Name (If not institution, give street and number)  4b. City, Town, or												
	ANNE ARUNDEL MEDICAL CENTER ANNAPOLI							S	ANNE ARUNDEL				
ineral	5. Social Security N		6. Sex 1 ☐ M 2 ☐ F		n yrs. last birthday) 86 Yrs.	If Under 1 Yaar Months Days		8. Data of Bi (Month, D	ay, Year)		lace (Stata or For		
rector	578-26-8723   1   M 243   86 Yrs.   AUG. 08,1912   Usual Residence of Decedent							VIRG	INIA				
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to de	MARYLAND ANNE ARUNDEL ANN.				NNAPOLIS	NAPOLIS			1 ☐ Yes 25				
be notified Director	10a. Street and Number					10f. Zip Code			10g. Citizen of What Country?				
23	1801 HOLLY BEACH FARM ROAD					21401			UNITED STATES				
forms 234	11. Maritat Status  12. Was Decedent Ever in Armed Forces?				n U,S. 13. Was Decedent of Hispanic Origin? (Sp If Yas, specify Cuben, Mexican, Puerto			ecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.					
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2 2 2 2	20a. Method of Dis	Cremation :	3 □Removal from		20b. Place of Dispo cematary, crer	metory or other ple	oce)	Date	20c. Location -	City or To	own, Stata		
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any ir	21. Signature of Funeral Service Licensus JOHN M. TAYLOR FUNERAL HOME, I												
- 4 0	147 DUKE OF GLOUCESTER ANNAPOLIS, MD. 21401												
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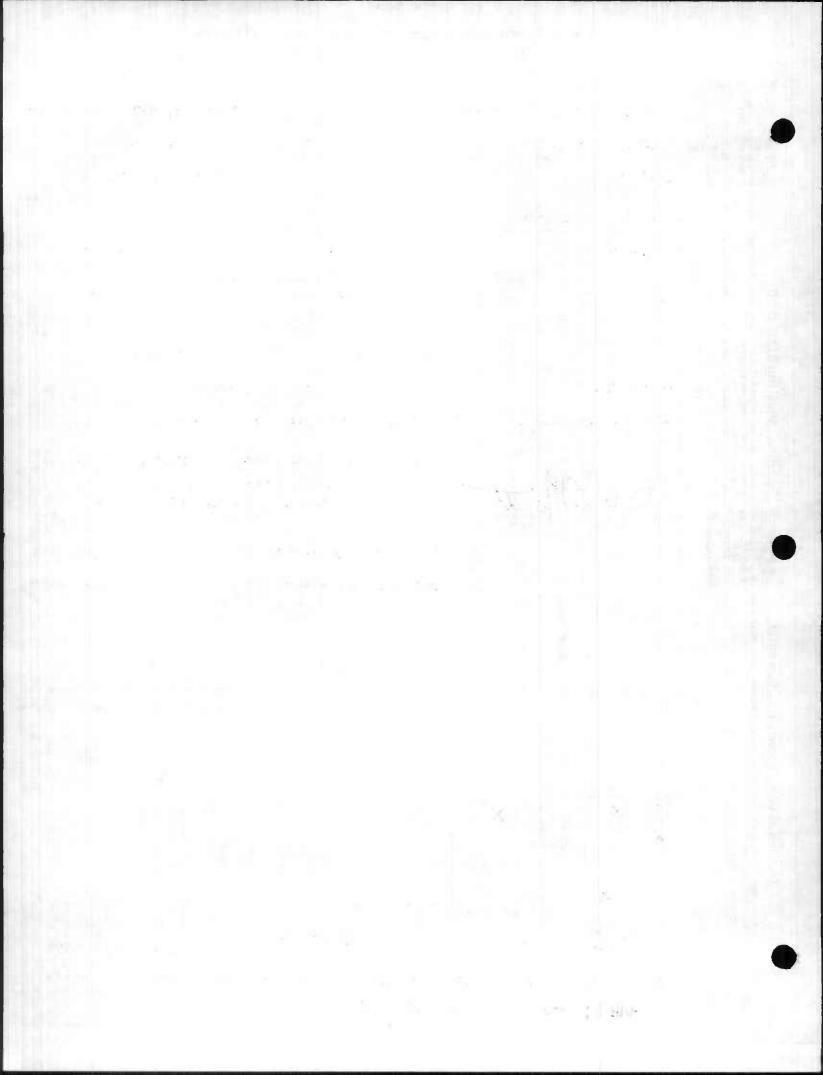
State of Maryland / Department of Health and Mental Hygiene \(\)

Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2,1999 0300 am MAEBELLE FERN ZIMMERMAN March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) **Examiner** SACRED HEART HOSPITAL CUMBERLAND
It Under 24 Hrs. 8. [ ALLEGANY If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M 2 XF Yrs. **Director** 213-72-4571 85 SEPT 19 1913 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No MARYLAND ALLEGANY OLDTOWN Director 10f. Zlp Code 10g. Citizen of What Country? 10e Street and Number P.O. BOX#6 21555 U.S.A. daeth Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-it Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE by 3XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. HOUSE WIFE HOUSE WIFE . Pagas 1 and 2 should be filed v imant of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) ARTHUR WILSON MAGGIE (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) EUGENE L. ZIMMERMAN JR SON 12523 SUNSHINE DRIVE S.E. CUMBERLAND MD 21502 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If eny injury or once. SUNSET CEMETERY MARCH 5 1999 CUMBERLAND MARYLAND 22. Name and Address of Facility
MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND Approximate interval Between Onset and Death 23a. Part1. Enter the disease, of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE ONE DAY Examiner Due to (or es e consequence of): ONE WEEK Examiner INFLUENZA PNEUMONITUS cartificata be executed physician and tha bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 88 usa for signed by the a 23b. Did tobacco use contributa to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy tindings available prior to completion of cause of deeth? 24e. Was en autopsy performed? Completed need cartificate has lirector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Piece of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetlent 3 DOA this 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Aftar Attending 1 Natural 2 Accident 5 Pending Investigation daath. 1 Yes 2 No Director: / 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, tarm, street, tactory, offica building, etc. (Specify) in 24 hour.
The Funeral Dire.
The filled in by 4 Homicide 6 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signature and miles 29c. License number 29d. Date signed (Month, Dey, Year) March 2 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 1068 NATIONAL HUMBAY LAVACE MARICAND MIEN, M.O. JAMES R. 31. Date tiled (Month, Day, Year) MAR 0 3 1999 32 Registrar's Signeture State

**DHMH 16 Rev 6/95** 

Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

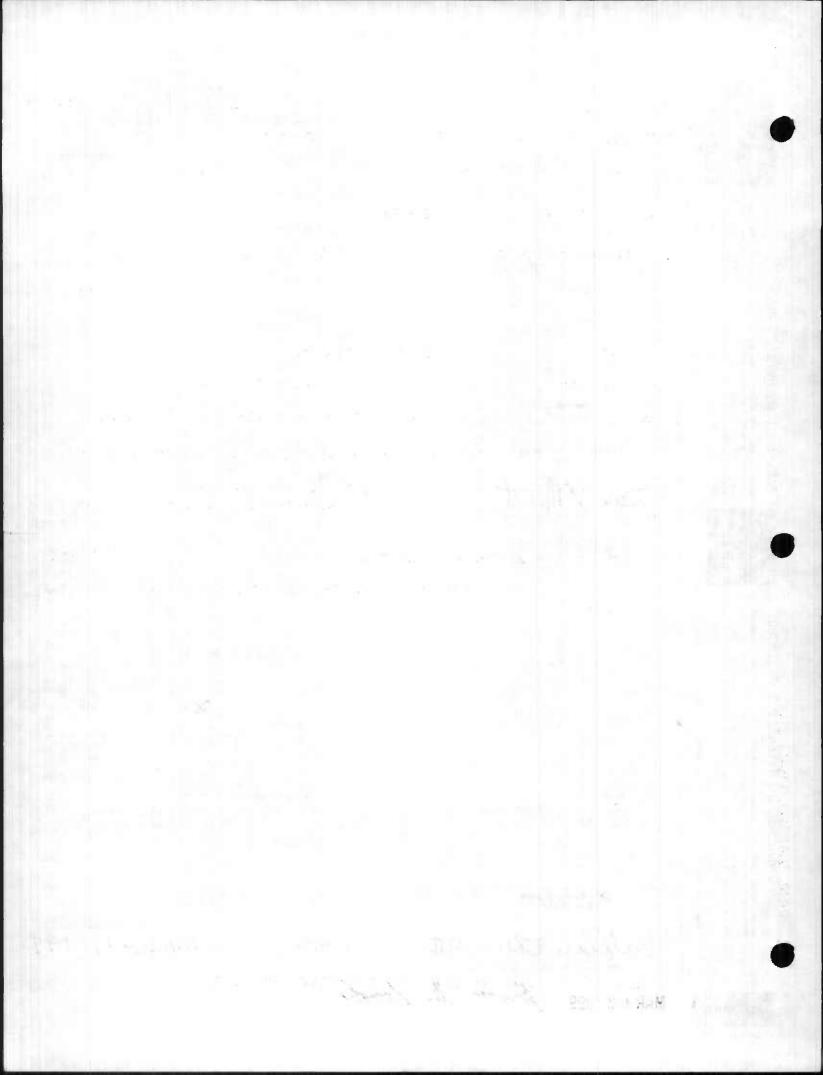
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARCH 1 1999 1:35 PHILIP CROUSE ZEMBOWER /Medical 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street and number) 4c. County of Death Examiner CUMBERLAND MEMORIAL HOSPITAL & MEDICAL CENTER ALLEGANY Hours Min. 8. Date of Birth (Month, Pay, Year) NOV 4 1912 If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months 1X M 2□ F Days Yrs PA. 86 Director 705-14-0246 Usual Residence of Decedent the Maryland 10d. fnside City Limits 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23s or 28s4 show traumatic event, ins Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No BEDFORD PA. BEDFORD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 15522 4438 BEDFORD VALLEY ROAD death 1 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health end Mental Hygiene.
Int: If item 27 is marked other than "natural", or the ury or other traumatic event, the Medical Evanture. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 □ Never Married 2K Married Specify: WHITE Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FARMER/WESTERN MD. RAILROAD FARMER 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be ELIZABETH HITE IRVIN ZEMBOWER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4438 BEDFORD VALLEY ROAD BEDFORD PA. 15522 WIFE EVELYN L.ZEMBOWER 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 【Cremation 3 ☐ Removal from State CUMBERLAND CREMATORY MARCH 3 1999 CUMBERLAND MARYLAND permit. Page Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lit 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Applications that cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final a. ASTHMATIC BRONCHITIS disease or condition resulting in death) 1 WEEK Examiner Due to (or as a consequence of): Examiner SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE 30 YEARS physician end s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that latticed successes or injury) Due to (or as a consequence of): PHILIP ZEMBOWER 705-14-0246 Division of Vital Records, P.O. Box 68760, The law requires that the daeth certificate be Physician/Medical that Initiated events resulting In death) Last Due to (or as a consequenca of) 98 980 0 23b. Did tobacco use contribute to the cause of death? detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yss 2 No 3 Probably 4 Unknown py Sign 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 s 1 Yes 2 No 1 Ves 2 No certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. fnjury at Work? 5 Pending eftar deeth. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi edical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Um MD D 25406 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 47 VIRGINIA AVE. CUMBERLAND, MD WILLIAM LAMM M.D., 21502

**DHMH 16 Rev 6/95** 

Registrar



1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician GLADYS B. ARTIS 20 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner LEVINDALE NURSING HOME BALTIMORE N/A If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 11-11-28 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□ M 2Q F 70 Yrs. 221-18-3315 Director **Usual Residence of Decedent** the Merylend 10b. County 10c. City, Town or Location r than "naturel", or items 23s or 28s-f show the Medical Examinar must be notified at Director BALTIMORE RANDALLSTOWN 10a Street and Number 10f. Zio Code 10g. Citizen of What Country? 3409 RIPPLE RD. 21244 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11 Marital Status permit. Peges 1 and 2 should be filed within 72 hours effer c Department of Heelth and Mertal Hygiene. Important: if Nem 27 is marked other than "natural", or fram any injury or other treumatic event, the Hedgell Emmin-Black, White, etc. 1 Yes 2 No If Yes, Give A Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK 2 3Ñ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) -12-College (1-4or 5+) NURSE HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALEXANDER BEAN EDNA L. BEVERLY 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN BROWN (DAUGHTER) 3409 RIPPLE RD. BALTIMORE, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date **D**Burial 2 ☐ Cremation 3 ☐ Removal from State DRUID RIDGE CEMETERY 3-25-99 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21 Signature of Funeral Service Licenses CFSP 1721-27 N. MONROE ST. BALTIMORE, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical MYOCARDIAL INFARCTION PRORABLE Examine Due to (or es a consequence of): Examiner CORONARY ARTERY DISEASE physician and the burlet-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

980 deteched signed by to d be detech been significant Dege 2 To the Hospital or Attendit within 24 hours efter deeth. To the Funeral Director: A completely filled in by the fu

Attending Physician:

Division

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Physician/Medical à Completed 8 Certification: To

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION DEMENTIA OLD CEREBROYASCULAR INSULIN DEPENDENT DIABTES MELLITUS.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Wunknown 24a. Was an autopsy performed?

2 No

24b. Were eutopsy findings available prior to completion of cause of death? 1 Tyes 2 No

Approximate Interval Between Onset and Death

3. Time of Death

N.J.

10d. Inside City Limits

1 ☐ Yes 2 ➡ No

8:40PM

25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 2 Natural 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 ☐ Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

ATTENDING (EC Caster PHYSICIAN MARCH 21. 1999 D 25610

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

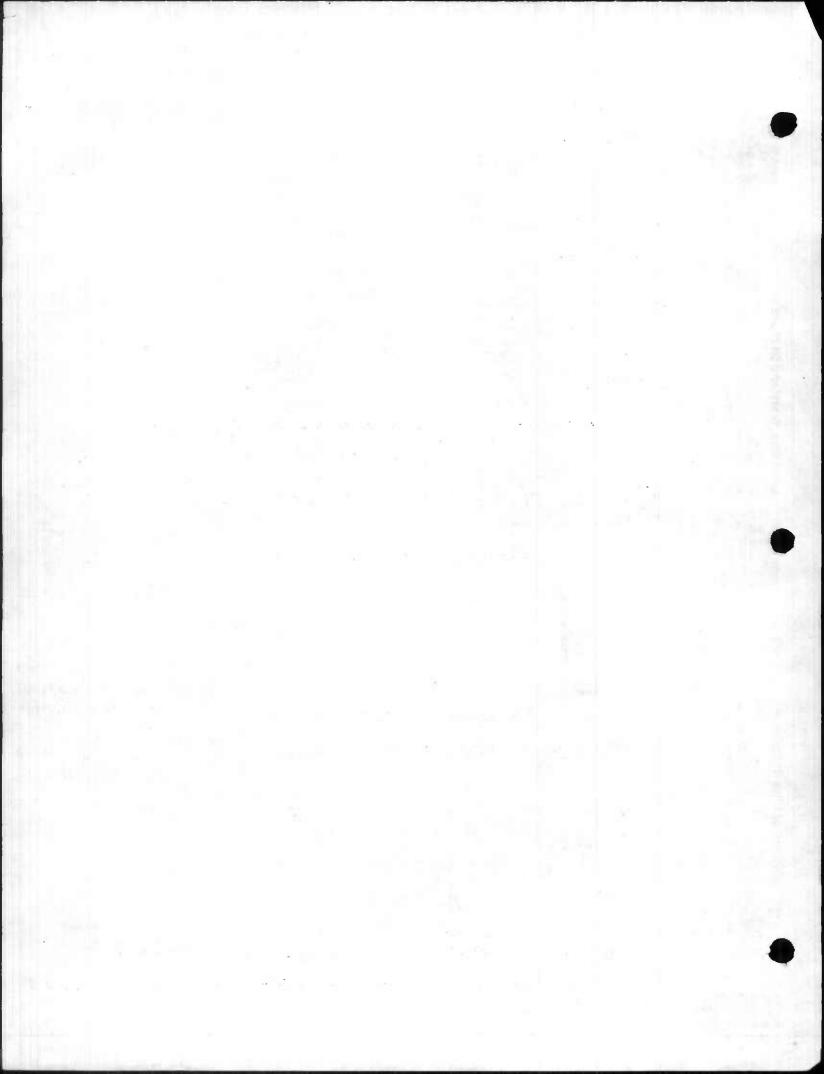
SET HTWAR M.D. LEVINDALE 2434 WEST BELVERDERE AVENUE BALTIMORE MD 21215 31. Date filed (Month, Day, Year)

State Registrar

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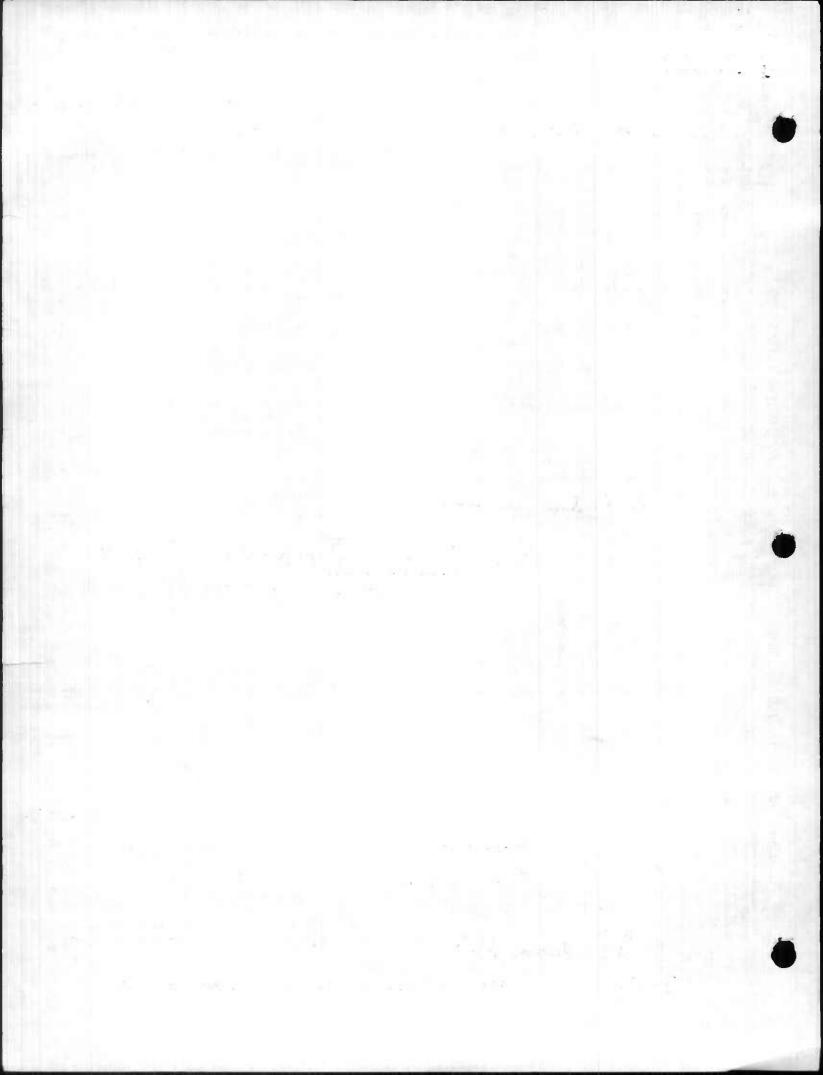
32. Registrar's Signature



DHMH 16 Rev 6/95

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AKINSE	EHINWA	a (First Middle	ast)	Carlo	Cer	tificate of	Deall	2. Data of De	Reg. No.		3. Time of Death
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Medical caminer	4a Facility Name (	If not institution, o					4b. City, Town, or L BALTIM	ocation of Deat	th 4c. Coun	y of Death	
neral ector	5. Social Security N 219-49-40	32	Sex 1√QM 2□ F	7. Age (In yr:	s. last birthday) Yrs.	If Undar 1 Year Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Bi (Month, Di 3 14	1979	9. Birthp Cour N 1 g	place (Stete or Foreign http) Eria
To Be Completed by Funeral Director	Usual Rasidanca o 10a. Stata	f Decedant 10b. County		10c. City, Town or Location						1	0d. Inside City Limits
to	Md	N/A Baltimore									1 Yas 2□No
irec	10e. Street and Nu	<i>m</i> ber				10f. Zip Code		10g. Citizen of	What Cour	ntry?	
a D	6933 Reisterstown Road					21215		Niger	ia		
by Funeral Director	11. Marital Status	iad 2 Married	Armed Fo	2XNo va		Vas Decedent of h Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, atc.)	Speci	ce - Americack, White, by: Bla	atc.
Be Completed	15. Decedant's Education (Specify only highest grade completed)  Elamantary/Secondary (0-12) UNK Collega (1-4or 5+)			1-4or 5+)	(Give	cedant's Usual Occupation UNK 16b. Kind of Businass/Industry UNK ive kind of work done during most of working e. DO NOT use retired)					dustry UNK
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	Peter Ak 20a. Mathod of Dis		va-Unlce			sition (Name of	ane cacon	Data Data	20c. Location		own Ctate
	1 🛱 Burial 2	☐ Cremation 3		Stata	cemetery, cren	natory or other pla Cemetery			Lansdow		
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	D la	0 0			1	March F/		D -	ltimore	Mal 4	21215
in/Medical Examiner	Sequantially list co if any, leading to in cause. Entar Unde Causa (Disaesa or that initiated avants resulting in death)		b c		(or as a consequence of the cons		njur	tior.	٦		
Physician/M	Part II. Other eignit	ficant conditions	contributing to d	eath but not re	sulting In the ur	ndarlylng causa gi	ven in Part I.		tobacco use c		o the cause of death?
Completed by									s an autopsy ormed?	av co of	are autopsy findings aflable prior to impletion of cause death?
0	25. Was casa rafar	rad to medical					26. Placa of Dea	th (Check only			2010
Certification: To B	axaminar? XXYas 2□ 27. Mannar of Deat 1 □ Natural 2 □ Accidant 3 □ Suicida 4 X Homicida	No  5 Panding invastigat 6 Could not datarmine	28a. Data 3/12/6 be de 28a. Place buildi Four	of Injury th, Day Year) Property of Injury - At ing, atc. (Space	homa, farm, stri Stree	Faul 28c. Inju Wo 1 Cast, factory, office	her: 4 Nursing H ny at rk? ] Yas 2 [12] No	oma 5 □ Ras 28d. Dascribe 5	how Injury occu	ASSA aber or Rura	ulted.  al Route Number,
edicai	29a. Cartifiar (Check only one)		miner: On tha b				ma, data and place opinion, daath occur				
Me	29b. Signature and	little of certifier	ner,	M.D.		29c. Licans	sa number		29d. Date sign		
State egistrar	30. Name and add	th, Dey, Yaar)	stand	legistrar's Sign	lll Penr		, Baltimo	re, Mar	yland 2	1201	



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MARY LUCY ALBRECHT March 4a Facility Nama (II not institution, giva straet and number) 4b. City, Town, or Location of Death 4c. County of Death Mariner Health of Bel Air Bel Air Harkord 8. Date of Birth (Month, Dey, Year) Feb. 9, 1920 5. Social Security Number If Under 1 Yaar | If Under 24 Hrs. 6. Sax 7. Age (In yrs. last birthday) 9. Birthpiace (State or Foreign 1 M 2 X F Days Min. Months Hours 79 Yrs. Tennessee 429-28-0283 Usual Rasidance of Deceden 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 314 Wakefield Drive U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - Amarican Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 Ø No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Homemaker Own Home 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Albert Asa Catherine Elmira 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 314 Wakefield Drive, Bel Air, MD. 21014 of Disposition (Name of Disposi Otto B. Albrecht (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) 1 X Burial 2 Cremation 3 Removal from State Pulaney Valley Mem. Gardens 3/22/99 Timonium, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee 610 W. MacPhail Road, Bel Air, MD. 21014 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ischemic Cardiomy opathy Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequenca of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Honknown Coronary Artery Disease 24b. Were eutopsy findings available prior to completion of cause of death? Adult Onset Diabetes 24e. Wes en eutopsy 1 Yes 2 No 1 □ Yes 2 □ No 25. Was cese referred to medical axaminar? 26. Place of Death (Check only one) 1 Yes 2 10 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Enursing Home 5 | Residence 6 | Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 5 Pending invastigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, straet, factory, offica building, etc. (Specify) 4 - Homicide 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one)

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> State Registrar

**Physician** 

/Medical

Examiner

Director

by

**Funeral** 

Director

7 is marked other than "naturel", or itema 23a or 28a-f show trsumatic event, the Medical Examinar must be notified at

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permit. Pages 1 and 2 should be filled.
Department of Health and Mental Humitroportant: If itsm 27 is mental any injury or other.

**Physician** 

/Medical

Examiner

Examiner

Physician/Medical

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Completed

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Certification: To

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director, page

the Maryland

31. Date filed (Month, Day, Year)

MAR 2 3 1999

29b. Signature and title of carrying

J. Kevin Lynch mo 2. Registrar's Signature

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

20

2 North oaks

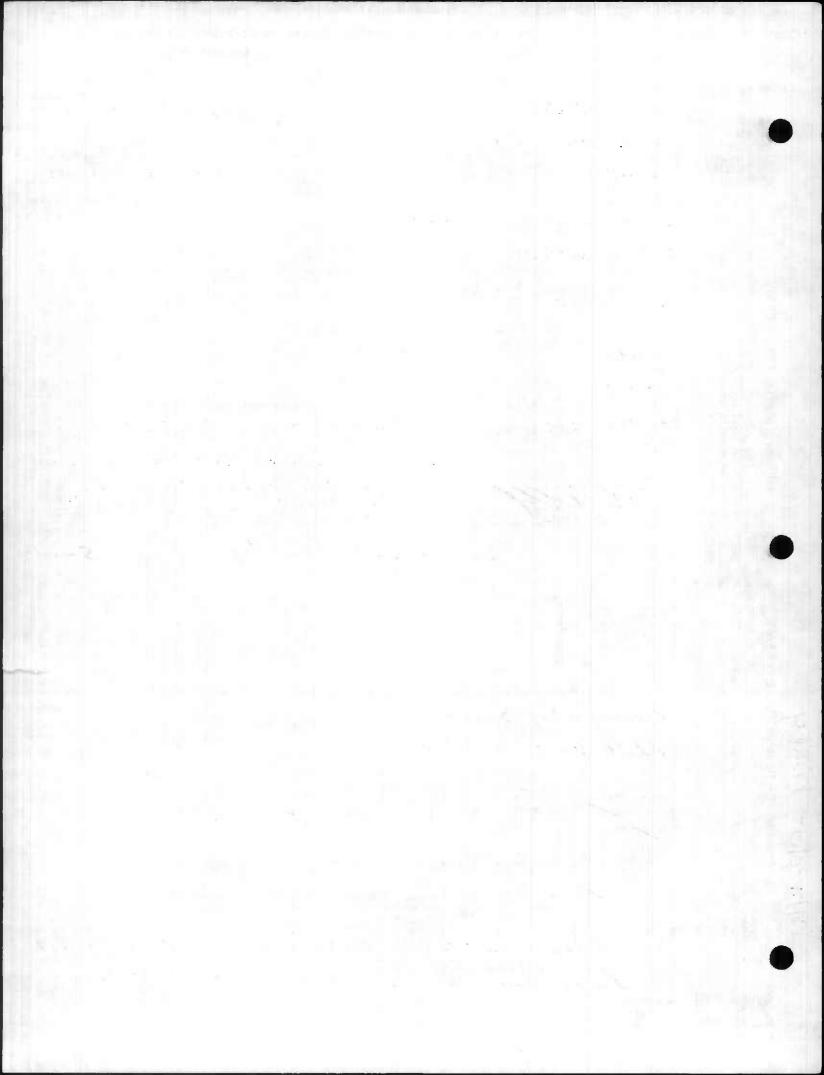
29c. Licansa number

135012

29d. Date signed (Month, Day, Year)

Ave. Bel Air, Md. 21014

march 19, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death Month **Physician** arrie Z: 47 PM 1999 /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Geriatrics (c If Under 24 Hrs. | 8. Date of Birth (Month, Day, Baltimore hdev) If Under 1 Year Johns Hopkins 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** Months Days 518-32-9989 1 □ M 2 1 F Yrs. WASh noton, D.C Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at 10d: Inside City Limits 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1822 21213 SA Street Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No tf Yes, Give Year or Dates: 11. Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural; or item any Injury or other traumatic event, the Maddall Essamme 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 20No Specify: þ Specify: 3 Vidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Secondery (0-12) College (1-4or 5+) MENIZON tedera 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wite Henry Hallie 19a Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Placa of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 3-26-99 Cordiner, Marylance Memorial Perk 4 ☐ Donation 5 ☐ Other (Specify) Harmony 21. Signature of Funeral Service Licensee

22. Name and Address of Eacility

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26. Tureral Hom

27. Name and Address of Eacility

28. Name and Address of Eacility

29. Name and A Funeral Home & Services Approximate Interval Between Onset and Deeth Physiclan /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or as a consequence of) that the death certificate be exec Records, P.O. Box 68760, (erebrovas Physician/Medical Due to (or es e consequenca of): tensu ned by the attent detached for u Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 3 □ Probably 4 Unknown 1 ☐ Yes 2 ☐ No by 8 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Waa an autopsy Bleed 2 No 1 Yes 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific funeral director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28e. Date of Injury (Month, Day Year) Certification: 27. Manner of Deet 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homlcide Certifying Phyalclan: To the best of my knowledge, death occurred et the time, date and placa, and due to the ceuse(s) end manner as stated.

| Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) pletaly 29b. Signature and title of sertifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5555 Hopkins Day

MD

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82. Registrer's Signature-

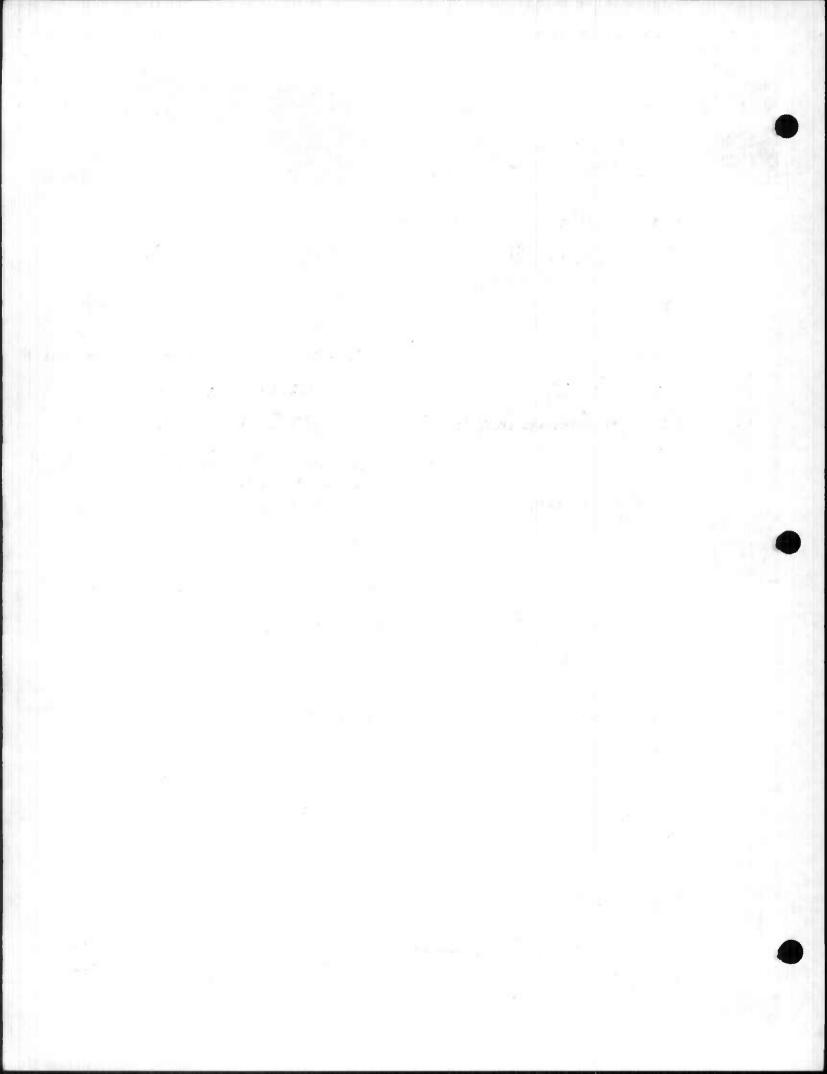
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MAR 2 3 1999

31. Date filed (Month, Day, Year)



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Dete of Deeth 3. Time of Death MARCH 20° 1999 SALVATORE PRCILES I 4a Facility Nama (If not institution, giva street and number) 9:56AM 4b. City, Town, or Location of Deeth 4c. County of Deeth GREATER BALTIMORE TOWSON MEDICAL CENTER BALTIMORE If Undar 24 Hrs. 8. Data of Birth Hours Min. Month, Day, Yeer) If Under 1 Year Birthplece (State or Foreign County) D. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Deys 1 M 2 F 212-28-7650A 68 NOU 5,1930 Usual Residence of Dacedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No BALTO, Cily MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code VORTHERN MARKWAY 2/2/4 13. Was Decedent of Hispenic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puarto Rican, atc.) Was Decedant Evar In U,S. Armed Forcas? 14. Race - Amarican Indien, 11. Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College/(1-4or 5+) FOOD + LIQUER TAVERN OWNER B 17. Fether's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Malden Surname) AGATHA DITRADONI 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) RiNGS UNE Dete 20c. Location MD. 21087 OSEPH Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetlon 3 Removel from Stete 4 Donetion 5 Other (Specify) CREMATORY 21. Signature of Funeral Go 22. Nama and Address of Fecility S DELLA NOLETS 322 S. HGN ST. FUNERAL HOME ONS Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast shock, or head failura. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Cause (Finel diseese or condition resulting in deeth) Heart failure Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Coron cancer Due to (or es e consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 Unknown 1 Yss 2 No 24b. Were eutopsy findings available prior to 24e. Wes en autopsy performed? complation of causa of death? 25. Wes case referred to medical exeminer? 28. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) No No 1 Yes 1 Appetient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury at Work? Naturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es steted. | Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and plece, and due to the cause(s) end menner stated. 29a, Certifier

/Medical Examiner The lew requires that the death certificets be executed Division of Vital Records, P.O. To the Hospital or Attending Physicien: The within 24 hours after death.

To the Funeral Director: After this certificate it completely filled in by the funeral director, pag

**Physician** 

/Medical

**Examiner** 

Director

Funeral

by

Completed

2

Physician/Medical Examiner

by

Completed

Be

2

Certification:

edical

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Merylen Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner man be notified at once.

**Physician** 

attending physician and for usa as the bunel-transit

been signed by the s should be deteched

has

State Registrar

31. Dete filed (Month, Day, Year)

29b. Signature and title of certifier

6701 alb 32 Registrer's Signeture

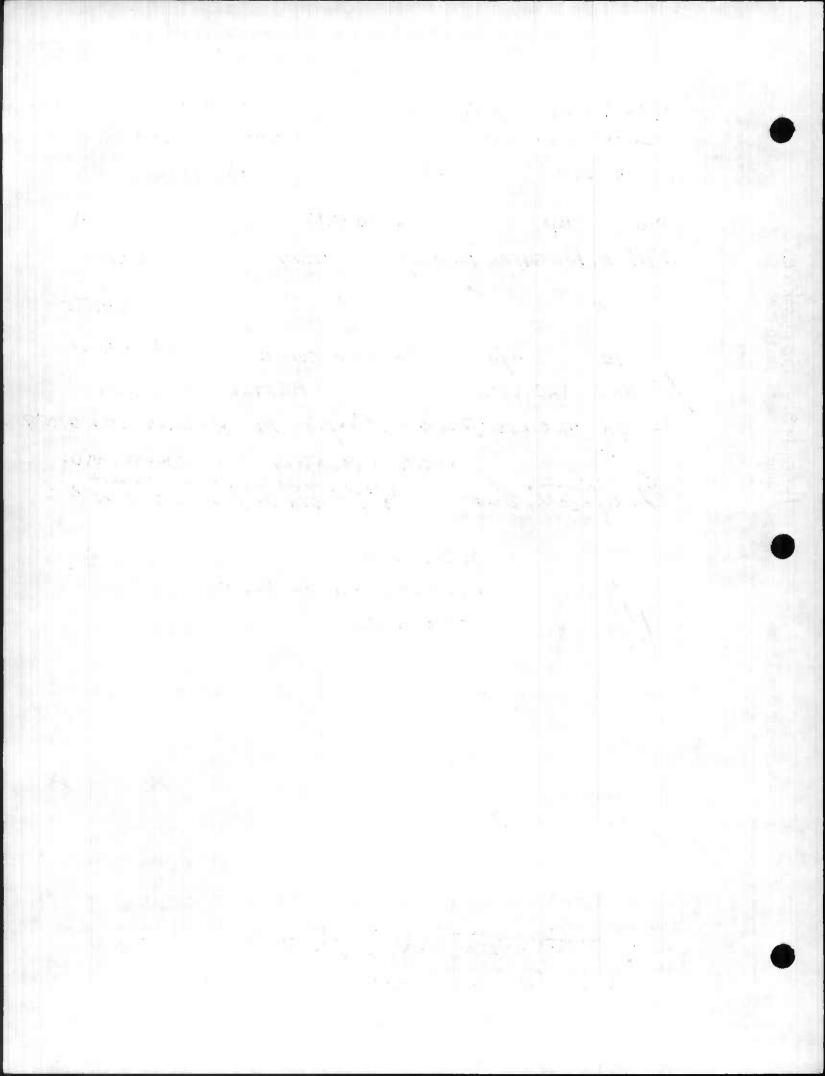
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Nchosile Sheet

29c. Licansa number

29d. Data signed (Month, Day, Year) 3/20194

Balknove MIZIQ04



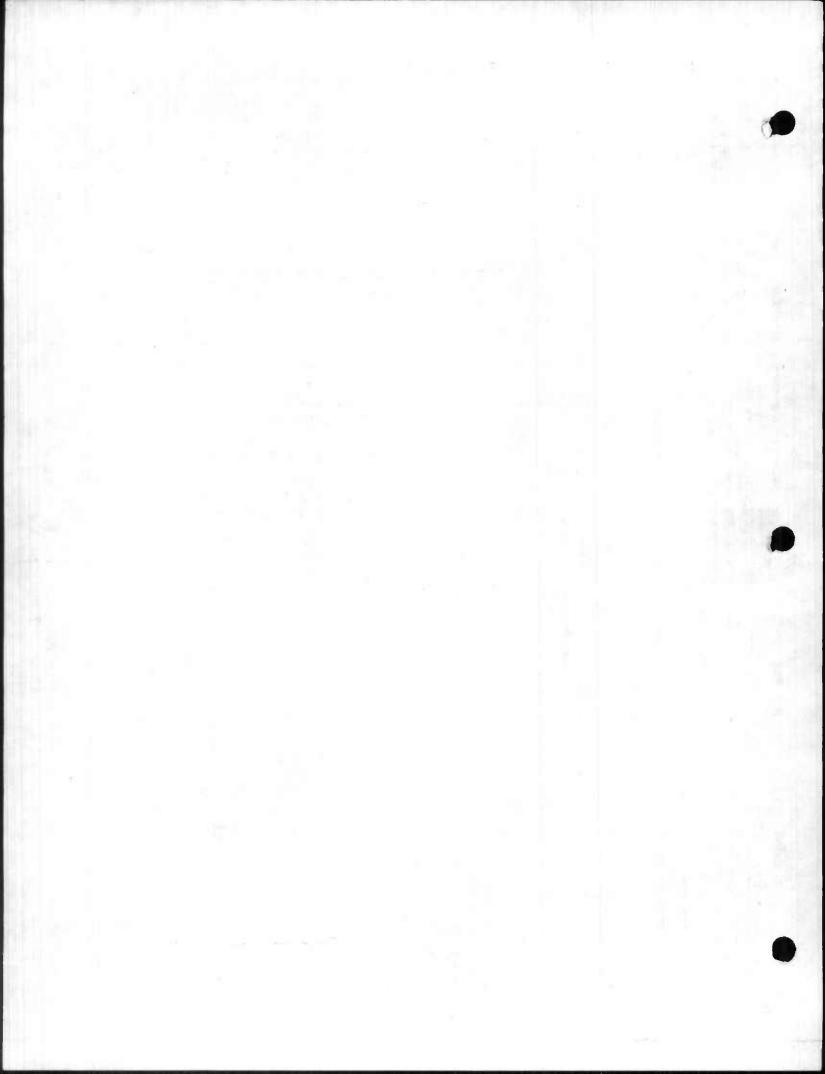
State of Maryland / Department of Health and Mental Hygiene

Items:p, per F.H.29c per V.R G-769 3/23/99 retificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Year Physician ARNOLD. R BERNSTEIN 1999 10:30Am Murch 20 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner UNION MEMORIAL HOSPITAL BALTIMORE If Under 24 Hrs. If Under 1 Year 8. Dete of Birth NOV 1934 5. Social Security Number 213-32-8683 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 64 Yrs. NEW JERSEY Md. MM 2DF Director Usual Residence of Decedent 10c. City. Town or Location PARKVILLE 10d. Inside City Limits Nerna. 23a or 28a-f show BALTTMORE the Medical Examiner rount be notfled at 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9211 ORBITAN ROAD 21234 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S
Armed Forces? 11 Marital Status Armed Forces? OAST 1X Yes 2 NEUARD If Yes, Give Yeer or Detes: hours after 1 Never Married 2 Merried natural, or altimore. Maryland 21215-0020 1□ Yes 2♥ No Specify: Specify: WHITE by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health end Mentel Physien. Important: if itam 27 is marked other tha any injury or other traumatic avent, its bonce. MANAGER NARON CHOCOLATE CO. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be SOLOMON BERNSTEIN SARAH SCHEINMAN 19a, Informent's Neme/Relettonship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLYDE FRIDLEY /FRIEND 9211 ORBITAN ROAD PARKVILLE MD. 21234 20e. Method of Disposition

↑ Buriel 2 □ Cremetion 3 □ Ramovel from State 20b. Plece of Disposition (Name of Dete 20c. Location - City or Town, State cemetery, cremetory or other piece) BALTIMORE HEBREW CEMETERY 3/22/99 REISTERSTOWN MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signeture of Funerel Service Licensee SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haert lailure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** immediate Cause (Final diseasa or condition resulting in death) /Medical Staphylococcus Examiner Dua to (or as a consequence of): Staphy lococcal Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest and Due to (or es e consequence of) The law requires that the death certificate be execu Box 68760 Physician/Medical the Due to (or es a consequence of) attending p Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown signed by due Records, þ 8 24b. Wera eutopsy lindings available prior to completion of cause of death? Completed 24a. Was an eutopsy peen 2 eged 1 Yes 25No 1 TYes 2 No certificate Division of Vital after deeth.

Director: After this certifica 25. Wes case relerred to medical examiner? director, Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Tima of 28d. Describe how injury occurred Medical Certification: 1 Neturel 5 Pending investigetion 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, lectory, office building, atc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely tilled in Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifian (Check only one) end manner steted. 29c. License number D-41593 29b. Signeture and title of certifier 29d. Date signed (Month, Dey, Year) 8506 10 88KE March 20 e mo. ASST Director ice 6.6 30. Neme and addrass of person who completed cause of death (Item 23a) (Type, Print) Peter Slowne MD 3333 N Calvert S+ #650 Balt, more mo 21218 31. Dete Illed (Month, Dey, Year) 32. Registrer's Signeture State MAR 23 1999 مصمديه Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 19a per F.H G-769 3/23/99 reb Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Adolph Wagner Burrier, Jr. 18, 1999 March /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9450 Seven Courts Drive Baltimore Baltimore 8. Date of Birth (Month, Day, Year) Aug. 20, 1927 If Undar 24 Hrs. Hours Min. Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sex 1X M 2□ F **Funeral** Months Days 71 Yrs. Maruland Director 216-20-4163 Usual Rasidance of Decedan with the Maryland 10d Inside City Limits 10a Stata 10h County 10c City Town or Location "naturel", or items 23a or 28a-f show 1 Yas 2 No Directo Maryland Baltimore Baltimore 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 21236 9450 Seven Courts Drive U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hyghera.
Important: If item 27 is marked other than "naturel", or ftems 233 eny Injury or other treumatic event, its Medical Evans en must Funeral 12. Was Dacedant Ever in U,S. Anned Forcas? 1-∆ Yas 2 □ No If Yas, Giva Yaar or Datas: WW II 14. Race - Amarican Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowad 4 ☐ Divorced Completed Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Dacedent's Education (Spacify only highast grada complated) Elementery/Secondary (0-12) 8th Grade Collega (1-4or 5+) Rail Car Inspector Railroad 18. Mothar's Nama (First, Middle, Maiden Sumema) 17. Fathar's Nama (First, Middla, Last) Be Mildred Stroble Adolph Wagner Burrier, Sr. 19a. Informant's Name/Ralationship (Type, Prigt) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 9450 Seven Courts Drive, Baltimore, MD (daughter) Beverly Burrier 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata 3/20/99 Baltimore, Maryland Green Mount Crematory 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility
Schimunek Funeral Home, Inc. 21. Signatura of Funaral Sarvice Licensee 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onsat and Daath **Physician** /Medical Immediate Causa (Final disaasa or conditio rasulting in daath) Examiner Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-transit Sequantially list conditions, if any, leading to immadiate causa. Enter Underlying Causa (Diseasa or injury that Initiated avents rasulting in death) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of) attending for use as signed by the a Part II. Other alignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Mallitus 2000 þ 24b. Wara autopsy findings available prior to completion of cause of death? been si Completed 24a. Was an autopsy this certificate has 1 Yas 2 N/NO 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

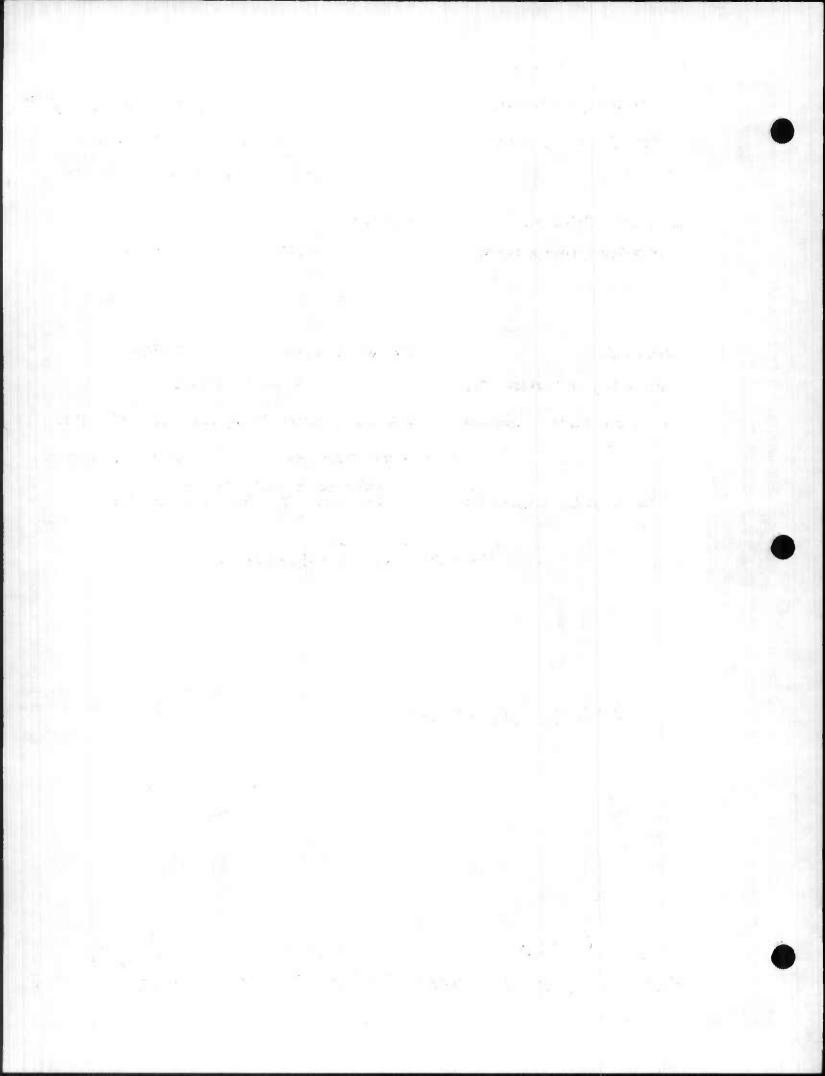
To the Funeral Director: After this certifica completaly filled in by the funeral director, t Be 25. Was case refarred to medical 26. Placa of Daath (Chack only ona) examiner? Othar: 4 ☐ Nursing Homa → Basidenca 6 ☐ Othar (Specify) 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d Describe how Injury occurred Certification: 5 Pending Investigation 1 Natural 1 Yas 2 No 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be datermined 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifian edical (Check only one) 29b. Signatura and the of 29d. Date signed (Month, Day, Year) 29c. Licanse numbar 30. Nama and addrassis mpleted cause of deeth (Itam 23a) (Type, Print) 7600 1ep 5 LOWSON NOURSIN 31. Date filad (Month, Day, Year) 32. Registrer's Signetura

Registrar

State

3 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARYCH 20 Day 999 Year **Physician** STANISLAUS STANLEY PETER BRZUCHALSKI 1:23 PM /Medical 4c. County of Death Baltimore 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner Center Saint Joseph Medical Towson Birthplace (State or Foreign Country) 5 Social Security Number 7. Ann (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 X M 2 □ F Days Director 220-14-0516 74 January 10,1925 Baltimore, Maryland Usual Residenca of Decedent 10c. City, Town or Location 10a State 10h County 10d Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at with the Maryle 1 Tyes 2X No Baltimore Co. Directo Maryland Towson 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 111 West Road 21204 United States of America Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? W.J.I. 1 X Yes 2 No3/2//43 If Yes, Give 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Married 2 X Married altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: by White 4/05/46 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 08 Merchant Seaman n/a Federal Government other 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Pages 1 and 2 should be facent of Health and Mental Int: If them 27 to marked of Adam Marion Brzuchalski Elizabeth Emelia Haluch 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Cheryl D. Tyson (Daughter) 4040 West Luke Ave. Phoenix, Az. 85019-2002 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 X Bunal 2 Cremation 3 Removal from State 6 permit. Page Department of Important: If any Injury or page. Garrison Forest Veterans Cem. 3/24/1999 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Jeffrey L. 22. Name and Address of FacilityRuck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DAYS **Physician** SEPSIS /Medical Immediate Cause (Final disease or condition resulting in death) Examiner GANGRENE OF CONSEQUENCES OF I NES DAYS Examiner ettending physicien and for use es the buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) 80 signed by the eligible between the Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy director, pege 2 should Completed been : certificate hes 200 No 1 ☐ Yes 1 ☐ Yes Attending Physician: 25. Wes case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Ves 3 No 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P this funerel 27. Manner of Deet 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Neturel 2 Accident 5 Pending after death. 1 Yes 2 No Investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 | Homicide Hospital or 24 hours 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and manner es steled.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number allah J. Heloy M. S 17695 March 22, 1999 30 Name and address of person who completed cause of death. (Hem. 23a) (Type, Print) DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar **DHMH 16 Rev 6/95** 

MAR 2 3 1999



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Division of Vital Records, P.O. Box 68760.

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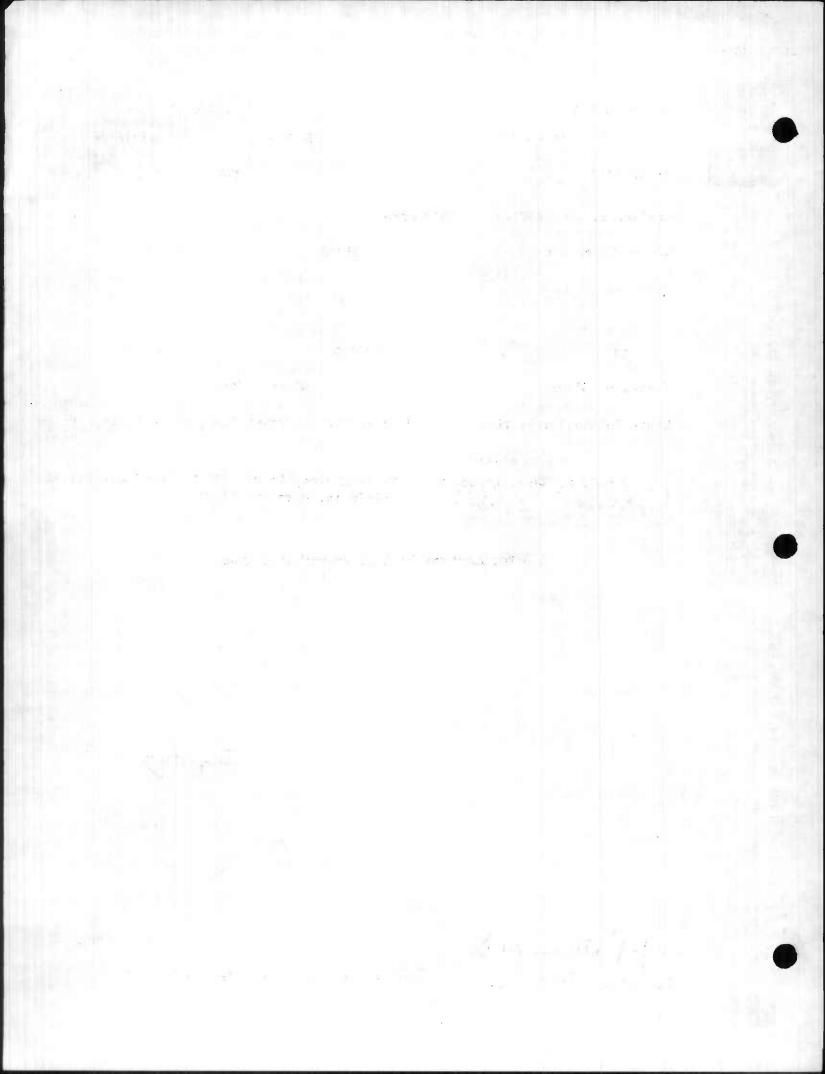
State of Maryland / Department of Health and Mental Hygiene 9

										Reg. No.		
in al	1. Decedent's Neme (First, Middle Samuel Biggs								2. Dete of De Month MARCH	Day 19	Yeer 99	3. Time of Death 0930
er	4a Facility Name (If not institution 820 SOUTH CATO						4b. City, To BALT		cation of Death E			e City
	5. Social Security Number 214-44-2111	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs 53	. lest birthdaj Yrs.	y) If Under Months	1 Year Deys	If Under Houra	24 Hrs. Min.	8. Dete of Bird (Month, De Feb.	h y, Year) 1, 1946		lace (Stete or Foreign try) KNOWN
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al Director	10e. Street and Number 10f. Zip Code 820 S. Caton Avenue 2122								10g. Citizen of What Country? U.S.A.			
by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed I	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:		13. Was Decedent of Hispanic Origin? (Siff Yes, specify Cuben, Mexicen, Puerton 1 ☐ Yes 2 ☑ No Specify:			gin? (Spe n, Puerto			ace - Americen Indien, leck, White, etc.	
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	17. Father'a Neme (First, Middle, Samuel H. Big								Neme (First, Middle, Maiden Surname) or Hart			
	19e. Informent's Name/Reletions	nip (Type, Print)		19b. Me	iling Address	(Street	and Numb	er or Rura	al Route Numb	er, City or Town,	State, Zip	Code) 28100
	Louis Politow:  20a. Method of Disposition  1 Burial 2 Cremation		20b.	Piece of Dis	06 Sec	ne of		turt	Road, P	Monroe, N		Carolina own, State
	21. Signature of Funeral Fervice.  23a. Pent 1 Enter the diseese or shock or heert failure. List	complications that	t ceused the dec	oth. Do not e	enter the mode	ore	, Mary	land	d 21201 or respiratory e			Approximete Interval Between Onset and Death
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State Registrar

Joseph Pestance 32. Registrer's Signature 31. Dete filed (Month, Dey, Year) MAR 2 3 1999

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death Month Year **Physician** BACKUS MARION N)ARCH 1999 16 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KANDALLSTOWN CENTER HOSPITAL BALTIMORE JORTH WEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Pay Year) 9. Birthplace (State Country) Virginia 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 9. Birtholace (State or Foreign **Funeral** Days Months Hours 1□M 20 F 66 215-30-5018 **Director** Usual Rasidence of Decedent The Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Baltimore County 1 ☐ Yes 2 ☑ No Directo 28a-f 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ъ 238 3512 Abbie Place 21244 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Giva 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0020 natural, or 1 ☐ Yas 2 ☐ No Specify: Specify: **Black** þ 3 ☐ Widowed 4 ☐ Divorced Yaer or Detas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 0 Unknown Supply 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) permit. Pages 1 and 2 should be fit Department of Health and Mental H Important: If flem 27 is marked oth any injury or other traumatic even Be Andrew Arker Fisher Addie Lena Baynham 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Israel Backus/wife 3512 Abbie Place, Baltimore, Maryland 21244 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removet from Stete 4 Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Ronald S. Wade 22. Nama and Address of Facility
State Anatomy Board, 655 W. Baltimore Street Director Mes mount-Baltimore, Maryland 21201 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failura. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical THEROSCLEROTIC CARDIOUNSCULAR Examiner Due to (or as a consequence of): Examiner MELLITUS 1ABETES ician and burial-transit Sequentielly list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) physician s the burial Box 68760. PERTENSION Physician/Medical Due to (or es a consequence of): 88 signed by the atte 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medicat axaminer? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 PER/Outpatient 3 DOA After this 28a. Dete of tnjury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 1 DNaturel 5 Pending death. 1 Tes 2 No Investigetion 2 Accident 24 hours after deat Funeral Director: 6 Could not be 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pieca of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end titla of cartifier NARCH 16 1999 Mace W. Queus MID DZZ751 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL CENTER RANDALISTOWN, MD JUSAN DWENS. MD NORTHWS8T

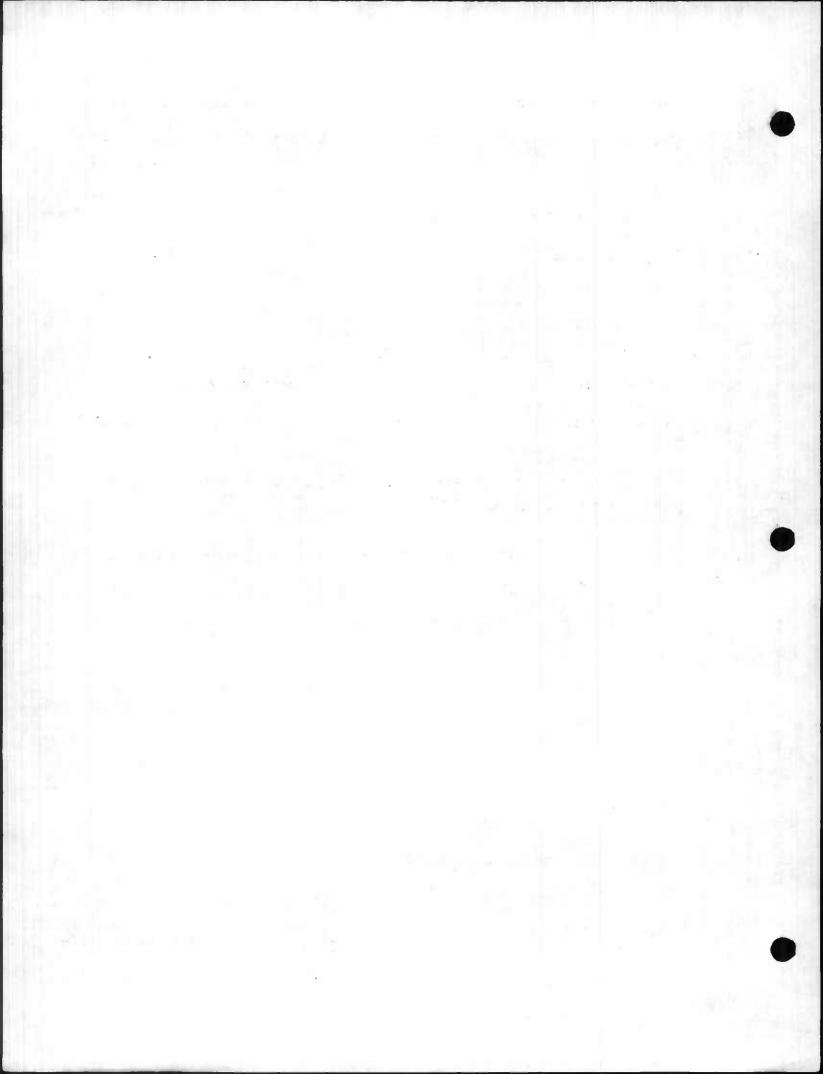
Registrar

State

31. Data filed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \( \) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Hargaret 1.00 AX. Harch /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Death BALTIMORE
If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Year) MARINER HRAITHOF Over lea 5. Sociel Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 6. Sex Birthplece (State or Foreign Country) **Funeral** 1 M 2 DyF Months Deys 94 Yrs. Director 217-20-7408 Usuel Residence of Dec 01/07/1905 Maryland 10e. Stete an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ty Yes 2□No Maryland Baltimore 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 128 S. Augustus Ave. Funeral 21229 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 Never Merried 2 Married 1□ Yes 2□No Specify: Completed by 3 □ Widowed 4 □ Divorced Specify: Black Yeer or Dates: 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) Ties. Chef Restaurant 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mentel 2 Unknown Marie Wooden 19e. Informent's Name/Reletionship (Type, Print) Grand-19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zlp Code) . If item 27 or other tru Marie Scott-Revely- Daughter 1809 Druid Hill Ave., Baltimore, Maryland 21217 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremation 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Zion Cemetery 03/24/99Landsdowne, Maryland 22. Name end Address of Fecility The Derrick C. Jones Funeral Hm., 21. Signature of Funeral Service Licenses 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Pert1. Enter the disease, or complication and to caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final 2-36KB diseese or condition resulting in deeth) Examiner Due to (or es a consequence of): burial-tran Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Bnd Due to (or as e consequenca of): physician Physician/Medical the Due to (or es e consequence of) USB BS Pert tl. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Dtd tobacco use contribute to the cause of death? signed by 3 Probably 4 Dunknown 1 Yss 2 No ģ director, page 2 should 24b. Were autopsy findings evalleble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? peen 1 ☐ Yes 2 No certificata 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 10 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Megner of Deeth 28a. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 1 Neturel 5 Pending investigation 1 Tyes 2 No 2 Accident s after death filled in by the 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completaly filled Medical 29a. Certifier 1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner steted. 29c. License number D 30 66 1 29d. Dete signed (Month, Dey, Year) 29b. Signature end title of certifier

death with the Meryland

filed within 72 hours efter

21215-0020

Baltimore, Maryland

the death certificete be executed

The law requires that

Attending Physician:

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death.

P.O. |

Division of Vital Records,

State Registrar 31. Dete filed (Month, Day, Year) 3 1999

Sireeshe

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

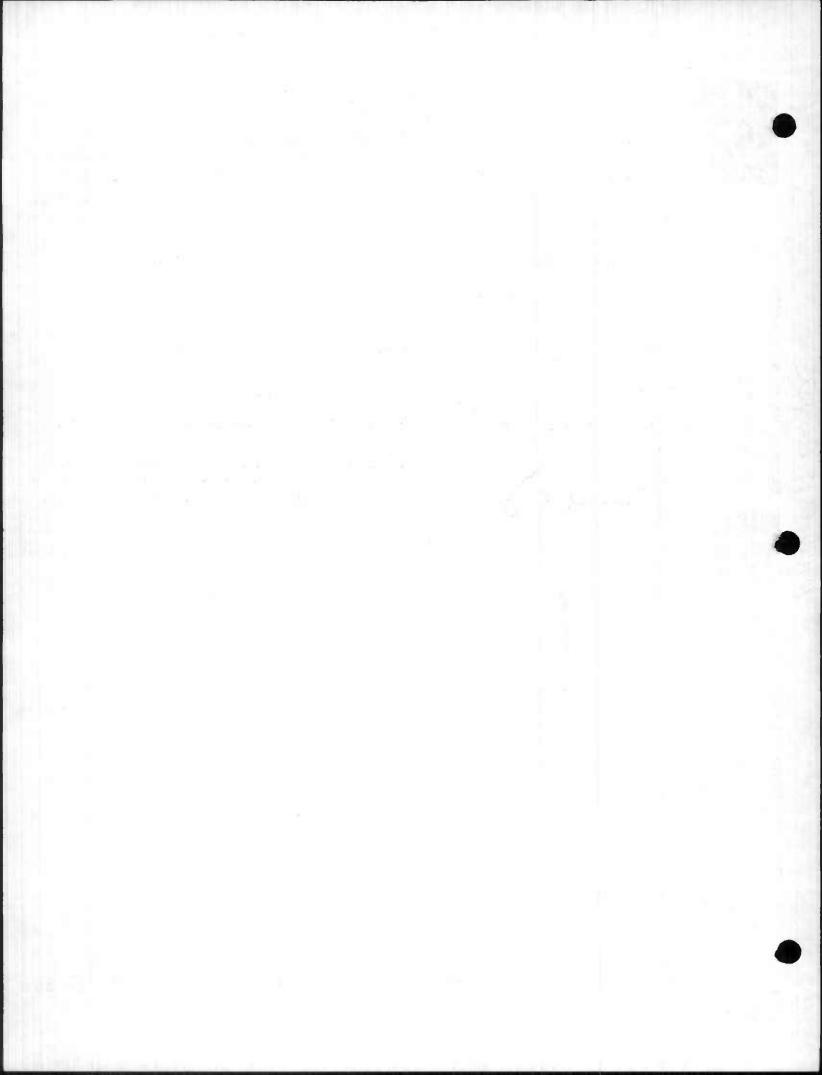
TRITURANENIE 32. Registrer's Signeture

Qualeur

560 1 Lock RAVEN BLUD. , BALTIMORE, MARYLAND

Harch 22

DHMH 16 Bey 6/95



### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6:30 PM MARUH Anna M. Currens al 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number, 4c. County of Death Bollif Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplaca (Stete or Foreign Country) Months Days Hours 1□M 27 F Yrs. 179-18-4011 Pennsylvania Feb. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 518 Carlsbad Court 21227 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yea 2 ☒ No If Yes, Giva Year or Datea: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 □ Divorced 15. Decedent'a Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife home 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) George Stragenig Anna Conahan 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Thomas Selph - son-in-law 518 Carlsbad Court, Baltimore, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stele 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 3/24/99 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funerel Service License 3620 Wilkens Avenue Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsat and Death 1 Week Immediete Cause (Final disease or condition resulting in death) 1-ncephalo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or ea a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the causa of death? 1 Yaa 2 No 3 Probably 4 Unknown 24a. Was en autopsy 24b. Wera autopsy findings available prior to completion of cause of daath? 1 Yes 2 No 1 Yes 2 No 25. Was case refarred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

NAME 6 To the Hospital within 24 hours a To the Funeral Completely filled

**Physician** 

/Medical

Examiner

Director

Funeral

à

Completed

10

**Funeral** 

Director

Examiner must be a

permit. Peges 1 and 2 should be filed within 72 hours after deeth 1 Department of Haelth and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 234 and injury or other traumatic event, in a Medical Example onds.

**Physician** 

/Medical

Examiner

ettending physicien end I for use as the burial-transit

After this certificate has been signed by the funeral director, page 2 should be deteched it

Director:

Physician/Medical Examiner

þ

Be Completed

edical Certification: To

29a. Certifier

Baltimore, Maryland 21215-0020

the Maryland x 28a-f ahow

WITH

State Registrar

29b. Signature and title of certifier

Howehre MD 29c. License number D46704

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the causa(s) and manner stated.

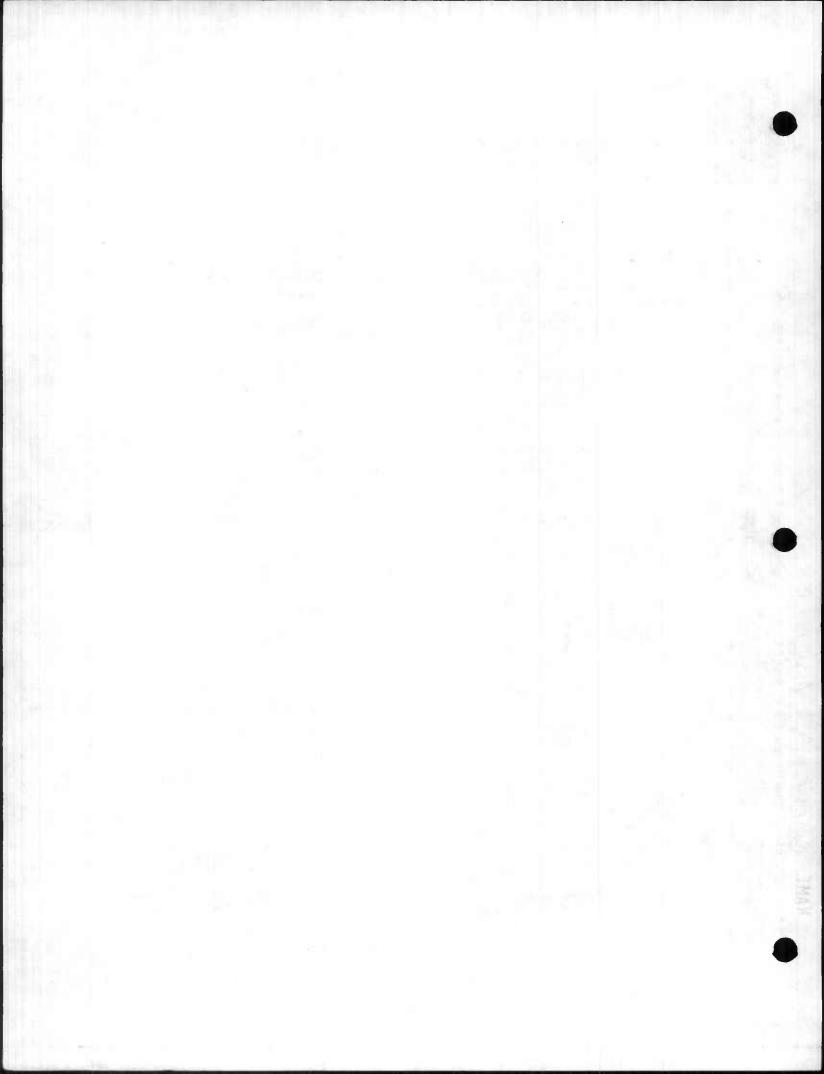
29d. Date signed (Month, Day, Year) 11999 MarcH 20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUTDINGO KANKONDO MUTOMBO

ACNES HOSPITAL BLT MD

31. Data filed (Moriff, Day, Year) MAR 2 3 1999 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Item 5 Per FH Film G769 3-24-99 rja Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** prace 14,1999 /Medical MARCH 02:43 PM 4e. Fecility Nema (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** MEDICAL CENTER

| Medical birthday | Minder 1 Year GREATER BALTIMORE TOWSON
If Under 24 Hrs.
Hours Min. BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 10 M 20 F Months Deys Hours Manslar Director NOV. 24 Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f show 1 Yes 2□No Director 10g. Citizen of What Country? ŏ 238 USY Funeral frems 14. Reca - Amarican Indian, Black, White, atc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cultan, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☑ No Blac Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 end 2 should be filed within 7 Health end Mantal Hygiene. em 27 Is marked other than "r Elementary/Secondery (0-12) Collega (1-4or 5+) Changeenr C.DM. 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be acab Costle Mary 19b. Mailing Address (Street and Number or Jural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Pfint) permit. Peges 1 end 2 s Department of Health er Important: If Item 27 Is 604 Boy Way Frances -wite other t Baltimore, 20b. Pleca of Disposition (Name of cemetery, crematory or other placa) 20e. Method of Disposition 20c. Location - City of Town, Stete 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State ò 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signeture of Funeral Service Licansee 23a. Pert1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onsat and Death **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) physician er s the buriel-t P.O. Box 68760, Physician/Medicai Due to (or as a consequanca of) Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ Completed 24b. Were autopsy findings available prior to complation of cause of death? 24e. Wes an eutopsy performed? Division of Vital or Attending Physician: 25. Wes case referred to medical exeminer?
1 ☐ Yes 2 ☐ No Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 1 Natural 2 Accident 28b. Time of 28c. fnjury et Work? 28d. Describe how injury occurred Aftar 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No aftar deatl Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours aftar To the Funeral Direcompletaly filled in b Certifying Physicien: To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) end menner as steted.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) 29a, Certifier Medical 29d. Date signes (Month, Day, Year) 29b. Signati

State Registrar

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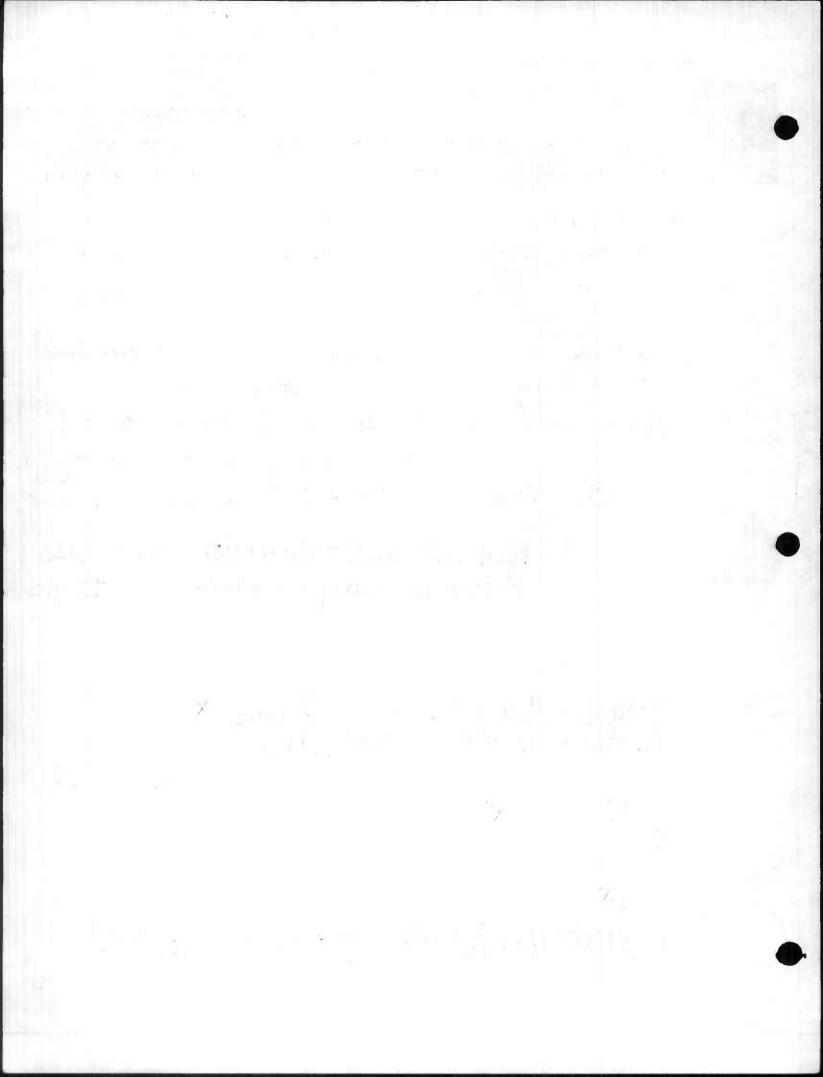
30. Neme end

Kartir MD. (70 Year) 32. Registrar's Signature

mpleted cause of death (Item 23a) (Type, Print)

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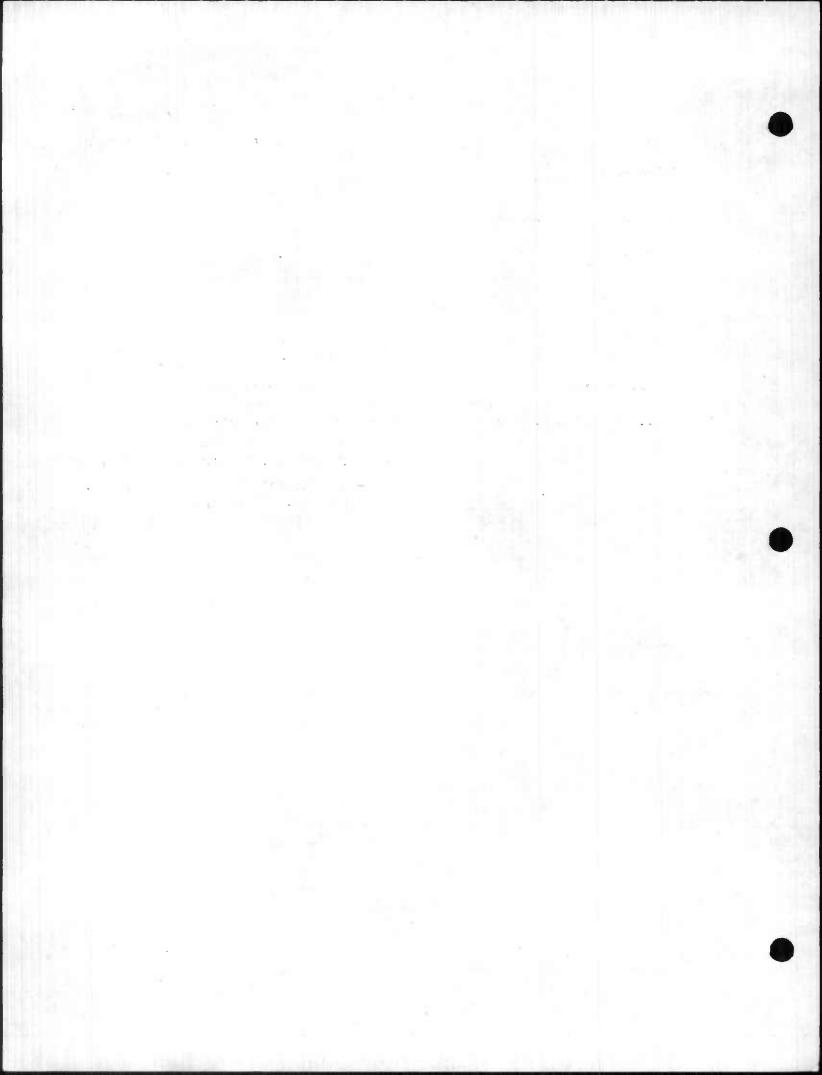
Charles



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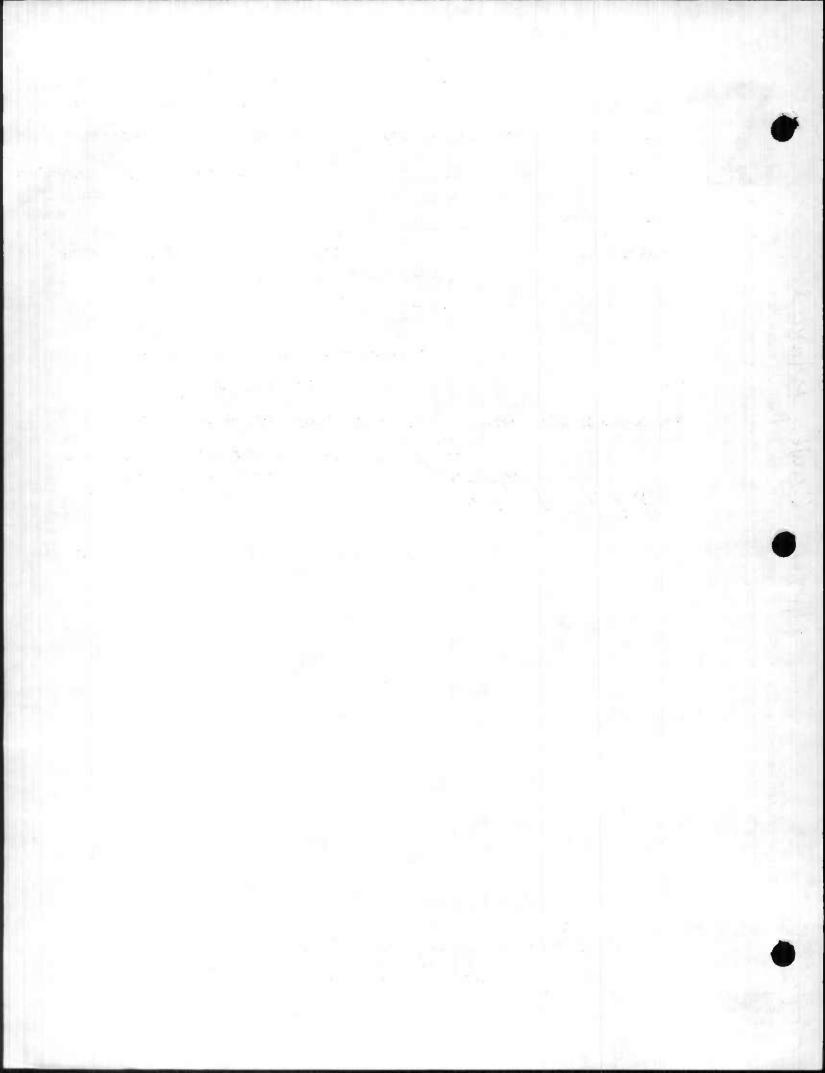
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** Robert Emmett Clarke 3:00 AM March 19, 1999 /Medical 4a Facility Neme (if not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2432 Keyway 5. Social Security Number Dundalk Baltimore If Under 1 Year 8. Date of Birth (Month, Day, Year) March 18,1916 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Maryland **Funeral** Days Min. Months Hours 1 M 2 F 83 Director 213-10-5891 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limita 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? "naturel", or items 23s or 21222 2432 Keyway United States death Funeral 11 Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 3 Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: by 3 Widowed 4 Divorced WWII White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Department of Health and Mental Hygiene Important: If frem 27 is marked other that only or other traumatic event, the 4 page. 2 Years Police Officer Baltimore City 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First Middle Maiden Surneme) Be James Clarke Mary Cadden 19e. Informent's Name/Reletionship (Type, Print) Wife 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Josephine J. Clarke 2432 Keyway Dundalk, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Moreland Mem. Park Cem. 3/22/99 Parkville, Maryland 22. Name end Address of Fecility
Duda-Ruck Funeral Home of Dundalk, Inc. 21 Signature of Funeral Service Licenses Johnny & Delex 7922 Wise Ave. Dundalk, Maryland 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervat Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel metastatic Melanoma diseese or condition resulting in death) years Examiner Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence ot): Box 68760 Physician/Medicai Due to (or es e consequence of): signed by the a P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, λq should I 24b. Were autopsy findings aveilable prior to completion of cause ot death? 24a. Was en autopsy performed? Completed page 2 1 Yes 2 No 1 Yes 2000 Division of Vital Be 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpetient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? or Attending Naturet 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28t. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Dire 24 hours 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. Medicai completely (Check only one) within 2 To the 29b. Signature and title of certities 29c. License number 29d. Date signed (Month, Day, Year) 038409 3/19/99 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) CIJAN 100 4940 Brimmas, rd SHM FANN WILLUM 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State Registrar MAR 2 3 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death **Physician** MARCH 2:40am Edward Beale Cagle /Medical 4a Facility Neme (ff not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F 213-01-0834 January 22, 1907 Baltimore, Maryland **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Baltimore Co. 1 Yes 2 No Maryland Towson Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 615 Chestnut Ave. 21204 United States of America 12. Was Decedent Ever in U.S. Armed Forces? W.W.I.I. 1 (X) Yes. 2 □ No 1177/43 It Yes, Give Year or Dates: 4/01/40 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 3 ☑ Widowed 4 ☐ Divorced 4/01/46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Retail Store Elamantary/Secondary (0-12) College (1-4or 5+) 12 04 Vice President of Finance Hochschild Kohn 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) is marked Rebecca Margosin Harry Cohen 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, State, Zlp Code) Health Hem 27 Mrs. Cornelia C. Cheney (Daughter) 2106 Round Hill Road Fallston, Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 Cremation 3 Removal from State Moreland Memorial Park 3/23/1999 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee Leffrey L. Gair 1050 York Rd. Towson, Md. 21204 that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, on each line. 23a. Ph. 1. Enter the disaa shock, or heart failure. Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) Bronchitis /Medical Examiner Dua to (or as a consaguance of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Diseasa or Injury that initiated evants attending physician and for use as the burial-tran Due to (or as a consequenca of): Due to (or as a consequence of): resulting in death) Last Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown uced 24b. Wara autopsy findings evalleble prior to completion of cause of death? Completed 24a. Was an autopsy **1990** certificate has 1 Yes 2 No Division of Vital 25. Was casa referred to medicel Be 26. Place of Death (Check only ona) 1 Yes 2 No Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA After this 27. Mannar of Death 28d. Describa how Injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Panding Investigation 1 Yes 2 No death. Director: d in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and dua to the ceuse(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 1)25205 who completed cause of death (Item 26a) (Type, Print) N. Charles St. Balto. md 21205 6 32. Registrar's Signature State MAR 23 1999 Registra

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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month March 19, 1999 **Physician** William. Moss Chairs 10:30 am /Medical 4e. Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson | H Under 1 Yaar | H Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Min. | March 9,1918 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpiaca (Stete or Foraign Country) **Funeral** 1₩ 2□F 213-07-7336 Yrs 81 Director Maryland Usuel Residence of Decedent with the Marriend r 28a-f show 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland N/A Baltimore 10e. Street end Numbar 10g. Citizen of What Country? 10f. Zip Code ir then "naturel", or items 23s or item Medical Examiner must be n 207 E. Melrose Avenue 21212 U.S.A. Pages 1 and 2 should be filled within 72 hours after deeth nent of Heaith and Mentel Hygiene. Funeral 12. Wes Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Bieck, White, etc. 1 ☑ Yas 2 ☐ No If Yes, Give WWII Yaar or Datas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry and Mentel Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Certified Public Accountant Accounting 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) William M. Chairs Elizabeth Moss 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health au Important: If Item 27 is any injury or other trau William M. Chairs, II/Son 623 Whitney Drive Slidell, La. 70461 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 20e. Mathod of Disposition Dete Buriel 2 ☐ Cramation 3 ☐ Removel from Steta Druid Ridge Cemetery 3/22/99 4 ☐ Donetion 5 ☐ Other (Specify) Pikesville, Maryland 21. Signature of Füheral Seryica License 22. Nema and Addrass of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 au plications of caused the death. Do not enter the mode of dying, such as cardlec or raspiretory arrest, one caused line. 23a. Pert1. Enter tha disease, or shock, or heart fellure. List Approximate Interval Between Onset and Deeth **Physician** /Medical immediete Cause (Finel diseesa or condition rasulting in death) 2 weeks Respiratory Failure Examiner Due to (or as a consequence of): Physician/Medical Examiner Pulmonary Interstitial Process 4 weeks physician and s the burial-transit The law requires that the deeth certificate be axecuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) for use as t signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown History of colon carcinoma and prostate carcinoma þ should l 24e. Was an eutopsy performed? 24b. Were eutopsy lindings available prior to completion of cause of death? Completed irector, page 2 s 1 Yes 2 No Ŷ Yes 2□ No Hespital or Attending Physician: "
It hours after death.
Funeral Director: After this certifica director. 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yas 2 ☐ XNo funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 DiNeturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, larm, street, fectory, office building, etc. (Specify) 5 4 Homlcide filled in 24 hours Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. 29e. Certifier Medical To the 29b. Signatura and title of certifian 29c. License number 29d. Data signed (Month, Dey, Year) Rebens d. Julius 03/20/1999 D36226 30. Name end eddress of person who completed causa of deals in m 23e) (Type, Print) Rebecca A. Ludwig, M.D. GBMC 6701 N Charles St., Baltimore MD 21204 31. Date liled (Month, Day, Year) 32. Registrar's Signeture State Sinera Registrar MAR 23 1999

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

HENRY DEMSKI State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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-	-	-		0	-

Physician
→ /Medical
Examiner

2. Date of Death 1. Decedent's Name (First, Middle, Last) MARCH Demski Henry 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE

19, 1999 8:08P.M. 4c. County of Death

10g. Citizen of What Country?

United States

**Funeral** Director

ir than "naturel", or itema 23a or 28a-f ahow

Director

Funeral

p

Completed

5. Social Security Number 7. Age (In yrs. last birthday) 1 **3** M 2 □ F Yrs. 213-07-6752 82

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 3, 19 Days Hours

 Birthplace (State or Foreign Country) Maryland

with the Maryland

death

72 hours efter

should be filed within nd Mental Hygiene. al Hygiene.

end Menta

permit. Peges 1 and 2. Department of Health er Important: If Item 27 is any Injury or other traugonce.

**Physician** 

certificete be executed physician and s the buriel-trans

Division of Vital Records,

/Medical **Examiner** 

> 86 use jo

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After

3

death.

or Attendation of the organization of the orga

within 2

Hospital

Examiner

Physician/Medical

þ

Completed

Be

10

Certification:

edical

Maryland 21215-0020

altimore.

10a. State Maryland

11. Mantal Status

Baltimore

10c. City, Town or Location Edgemere

10f. Zip Code

10d. Inside City Limits 1 ☐ Yes 2 No

3. Time of Death

10e. Street and Number

Usual Residence of Decedent

10b. County

12. Was Decedent Ever in U.S. Armed Forces?

Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

21219

14. Race - American Indian. Black, White, etc.

White

1 Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

2915 Delmar Ave.

1 □XYes 2 □ No if Yes, Give Year or Dates:

1 ☐ Yes 2% No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 9 Years

College (1-4or 5+)

Steelworker

Steel Industry

17. Father's Name (First, Middle, Last)

John Demski

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a, informant's Name/Relationship (Type, Print) Mrs. Julia Demski

2915 Delmar Ave. 20b. Placa of Disposition (Name of cemetery, crematory or other placa)

Edgemere, Maryland 21219 20c. Location - City or Town, State

20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Wife

Sacred Ht. of Mary Cem. 3/22/99

Dundalk, Maryland

21. Signature of Mineral Service Licensee

22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.

Date

18. Mother's Name (First, Middle, Maiden Sumeme)

Julia Olzewski

lase, o) complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, that only one cause on each line. 23a. Part1. Enter the demas shock, or heart to ure

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury

Due to (or as a consequence of):

Due to (or as a consequenca of):

that initiated events resulting in deeth) Lest

Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

20 No 1 Yes

3 Probably 4 Unknown

24a. Wes en autopsy performed?

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No

25. Was case referred to medical examiner?

1 Inpatient XXER/Outpatient 3□ DOA

26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1X Yes 2 No 27. Manner of Death 1 Natural

2 Accident 3 ☐ Sulcide

4 Homicide

5 Pending Investigation 6 Could not be determined

28b. Time of At home, farm, street, factory, office

26c. Injury at Work? 1 ☐ Yes 2 No

8/215 down Location (Street and Number or Rural Route Number, City or Jown, State) 28f.

29e. Certifier (Check only onii

HOME 4418 to Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the course(s) and mention as access.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and piece, end due to the cause(s) and manner stated.

29b. Signal and title of certifie 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) MARCH 20,1999

d address of person who completed cause of de to (Item 23a) (Type, Print)

RUN Witt 31. Date filed (Month, Day, Year)

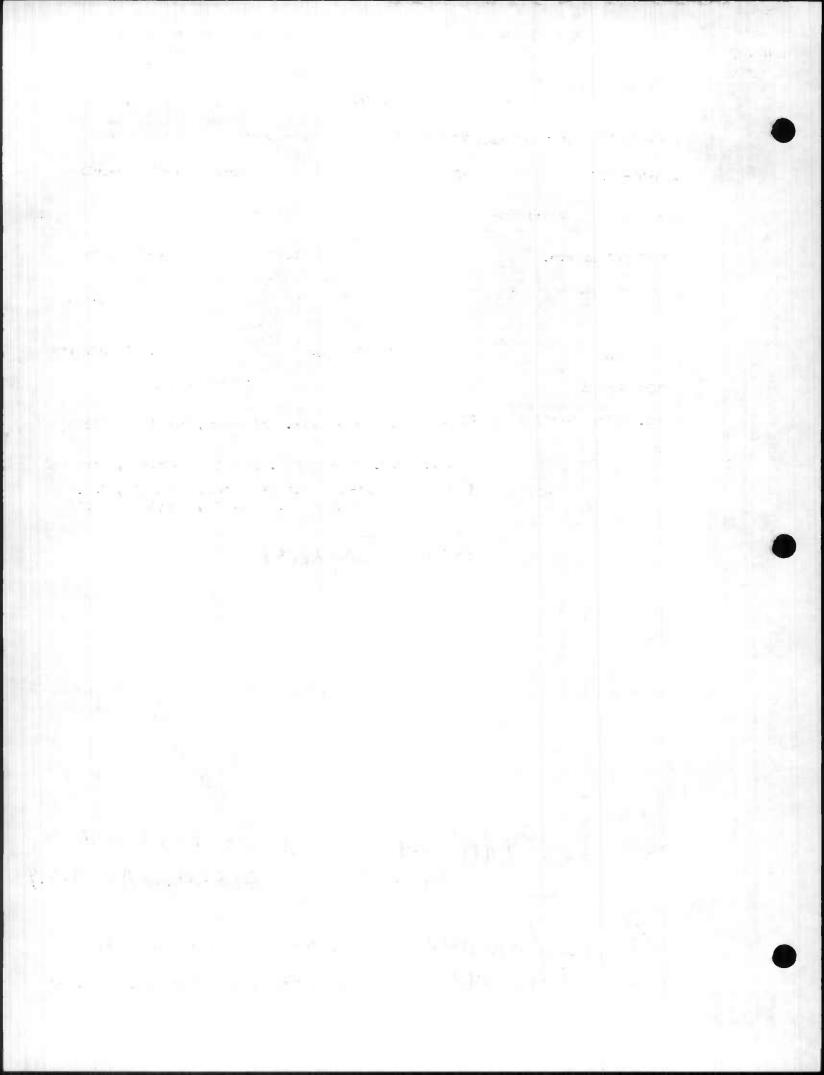
111 Penn Street, Baltimore, Maryland 21201

State Registrar

32. Registrar's Signeture

MAR 23 1999

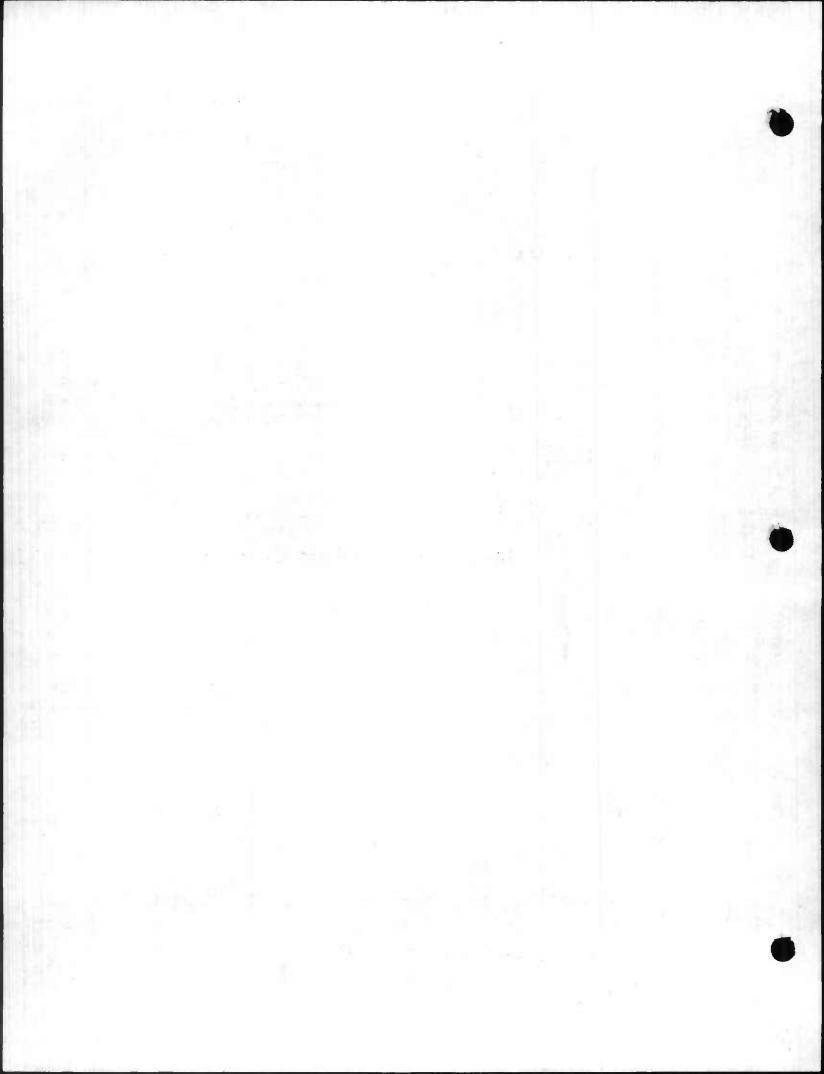




## Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1999 **Physician** MARCH 16, JULES DRESNER 5:15 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6350 RED CEDAR PLACE #405 BALTIMORE N/A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 BELGIUM 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Min. Days Hours 1 X M 2 □ F Months 73 1926 Director 009-18-7915 JAN. 26, Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 25a-f show 1 XYes 2 No Directo N/A MD BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ð munt be 6350 RED CEDAR PLACE #405 21209 therms 23a U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces? ARMY
1 Types 2 In No
11 Yes, Give
Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married altimore, Maryland 21215-0020 "nathirst", or 1 Yes 2 No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **ENGINEER** WESTINGHOUSE CORP. permit. Pages 1 and 2 should be fits Department of Health and Mental Hy important: If New 27 is marked other any Injury or other in-17. Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be **JACOUES** DRESNER PAULINE DRESNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) LILIANE DRESNER / WIFE 6350 RED CEDAR PLACE #405 - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEMETERY 3/18/99 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature 6 Aunarat Service Licent 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, and each line. Approximate tntervel Between Onset and Death **Physician** Adenocarcinous of bile ducts Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of) Examiner physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thal initiated events resulting in deeth) Last Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 100 1 Yee 2 No 3 Probably 4 ☐ Unknown NONE by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 108 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 | Inpatient Other: 4 Nursing Home 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funera 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 Netural 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and grapher stated. Medical 29a. Certifie (Check only one) 29b. Signature apolitile of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) 1838 GREENE TREE RODD BALTO, Md NALEN MD 32. Registrar's Signatur State

Registrar **DHMH 16 Rev 6/95** 



Registrar **DHMH 16 Rav 6/95** 

State

LA RON MO 31. Date filed (Month, Day, Year)

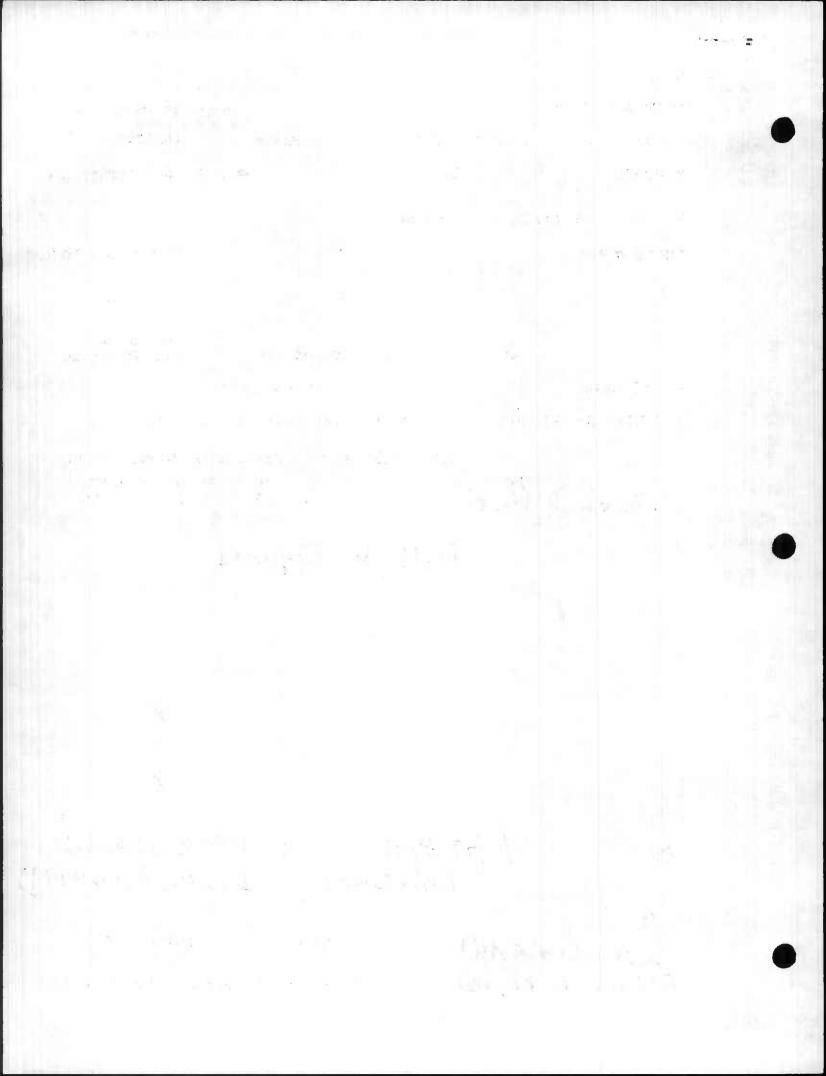
e and address of person who con

32. Registrar's Signatura

O.C.M.E

pleted cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

MARCH 20, 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** WALTER MARCH 20, 1999 DORSCH SR. CHARNER 5:30PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 7833 Shellye Road Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Hours | Min. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 X M 2 ☐ F Vrs 219-03-3705 Director JULY 24 1920 | MARYLAND Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or items 23e or 28e-f ahow the Medical Examiner must be notified at 1 ☐ Yas 2 ☑ No Directo Marvland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 7833 Shellve Road 21060 USA death Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritel Stetus Black, White, etc. 72 hours after 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore. Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Maryland State Road Contracting Engineer permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg important: if Nem 27 is marked other any Injury or other traument. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter R. Dorsch Beulah Unknown 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter C. Dorsch Jr. / son 2043 Larkhall Road Dundalk MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/23/99 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery 21. Signatura of Funerel Service Ligansee 22. Neme and Address of Fecility STALLINGS FUNERAL HOME P.A. 23a. Part 1. Enter the diseasa, or completition of et caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailore. List only on cause on each line. MD 21122 Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel Fibrillation disease or condition resulting in death) Examiner Examiner Condiovarentas disea physician and s the bunal-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceusa (Diseese or Injury that initiated events resulting in death) Lest Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 NUnknown bengis d be det Records, þ 24b. Were autopsy tindings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Be 25. Wes case reterred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of After or Attending 1 Netural 2 Accident 5 Pending investigation death. 1 Yes 2 No 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29e. Certifler To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature end 1/9e of certifian 29c. License number 29d. Date signed (Month, Day, Year) 17743 199

State Registrar

**DHMH 16 Rev 6/95** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

606 Hammonds Lane.

MAR 2 3 1999

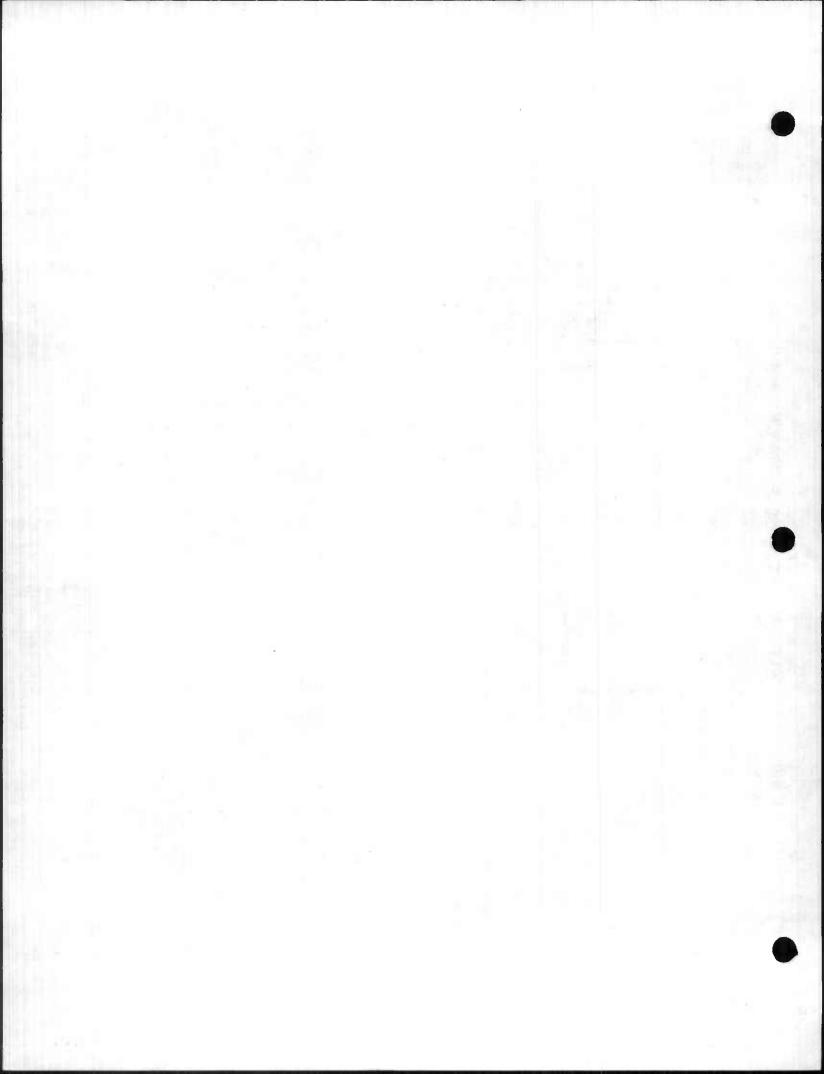
31. Dete tiled (Month, Day, Year)

Baltimore. MD

32. Registrer's Signature

22

SEENIVASAN, MD



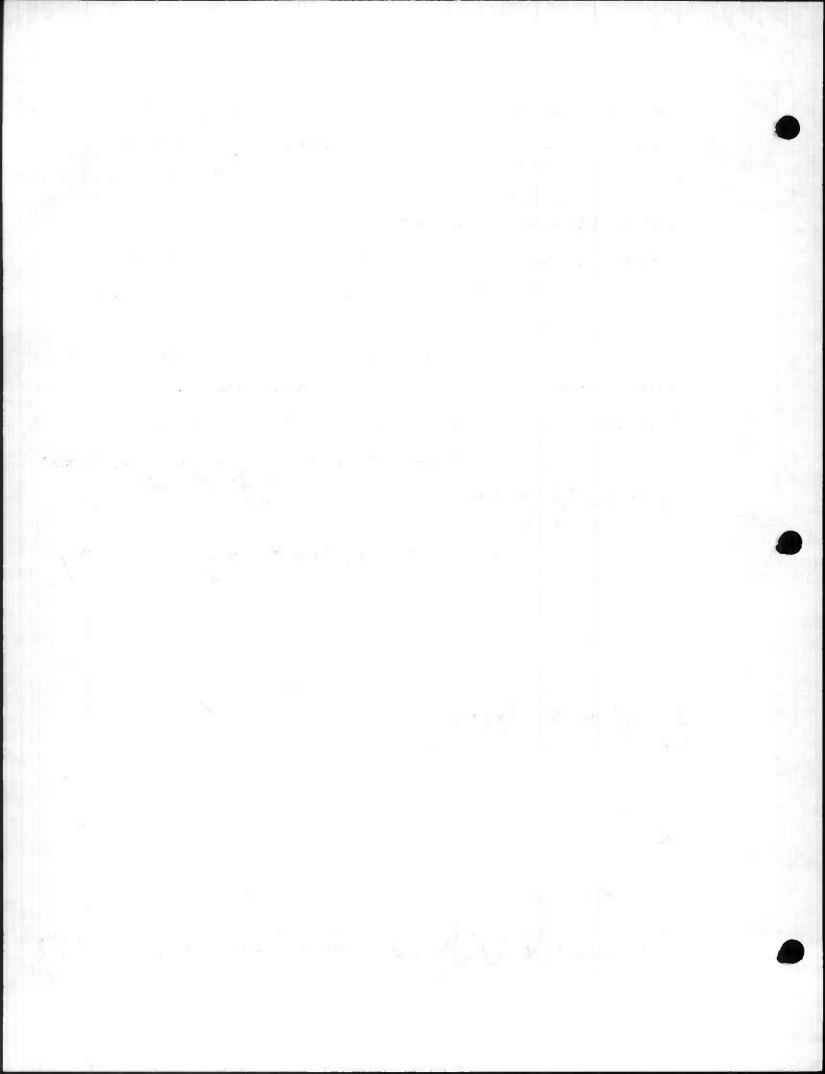
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 21, 1999 Charlotte Ruth Eldreth March 9:03 a.m. /Medical 4a. Feclity Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 5908 Robin Dale Road Baltimore Baltimore If Under 1 Year If Under 24 Hrs.
Months Devs Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** Months Deys Hours 1□M 200 F Yrs Director 233-40-6545 January 10,1927 West Virginia 72 Usual Residence of Decedant the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside Cltv Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g Citizen of Whet Country? ò "natural", or items 23a 21228 United States Funerai 5908 Robin Dale Road 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Detes: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: PY Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within 7 Health and Mantal Hygiene. em 27 is marked other than "r Elementary/Secondery (0-12) College (1-4or 5+) 12 machinist filling machines 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Joshua Thomas Spradlin Melinda Caroline Morris 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Peges 1 end 2.
Department of Heaith as Important: If item 27 is eny injury or other trau 1248 S. Grantley Street, Baltimore, Maryland Carol Pusinsky daughter 21229 Plece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 X Burial 2 ☐ Cremetlon 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/24/99 Loudon Park Cemetery Baltimore, Maryland 22. Name end Address of Fecility Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore, Maryland 21229 is that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, is on each line. Approximete Intervel Between Onset end Deeth Pert1. Enter the diseese, shock, or heart failure. L **Physiclan** Immediate Ceuse (Final diseese or condition resulting in death) /Medical sonay Instruction day Examiner Completed by Physician/Medical Examiner end I-transit Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Last Due to (or es e consequence of) physician er Box 68760, Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 0 Lung Cancer - Gyrs. ۵. 1 Yes 2 No 3 Probably 4 Unknown Records, Chronic Obstructive By money Disease 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy 1□ Yes 2 No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred After or Attending 1 Naturel 2 Accident 5 Pending investigation s after dee... 1 Tyes 2 No 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Discompletely filled in Certifying Phyelcien: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the ceuse(s) and menner steted. 29a. Certifier Medicai pleted cause of deal ussell & Delnea 5. Crain Highway, Steloz, 6/en bursie, M. UOb/ 1600 7.0. Day, Year) 32 Registrer's Signature

State Registrar

3 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year MITH Ebelein Patricia Ann 19, 1999 March 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8606 Silver Meadow Lane Baltimore Baltimore 8. Date of Birth (Month, Dey, Year) NOV. 27, 1943 If Under 1 Year If Under 24 Hrs. 9. Birthplece (State or Foreign 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Months 1 M 200 F Deys Hours 55 Yrs. Maryland 220-40-8395 Usuei Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8606 Silver Meadow Lane 21236 U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates: 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decadent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th Grade Coilege (1-4or 5+) Accounts Payable Clerk Defense Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) George R. Kaiss Bertha M. Appel 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Printhusband) Walter S. Ebelein, Jr. 8606 Silver Meadow Lane, Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 3/22/99 Baltimore, Maryland 22. Name end Address of Facility 21. Signature of Funeral Servica Licensee Schimunek Funeral Home, Inc. Buan 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. 21236 Approximate interval Between Onset end Death immediate Cause (Final 3 Mm disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yas 2 NO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 8 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

permit. Peges
Department of
Important: If it
eny injury or o

**Physician** 

/Medical

Examiner

10a State

Funeral

Director

r 28a-f show

Peges 1 and 2 should be filed within 72 hours after death with neat of Health and Mental Hygiene.

Intel if item 27 is marked other than -natural; or items 23a or item into or other than matter.

Directo

Funeral

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Completed

the Maryland

Examiner

Physician/Medical

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Completed

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Certification:

Medicai

1 Natural

2 Accident

3 Sulcide

29a. Certifier

4 ☐ Homicide

(Check only one)

physician and s the buriel-transit The law requires that the death certificate be executed attanding p SE signed by the a should should s certificata has b director, this funeral After

Division of Vital Records, P.O. Box 68760, or Attending Physician: To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completaly filled in by the fu death.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature end title of certifier

29c. License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

0100

Cut-

1 Yes 2 No

29d. Dete signed (Month, Day, Year)

Location (Street and Number or Rurel Route Number, City or Town, State)

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)

Scrpick Arthe,

5 Pending investigation

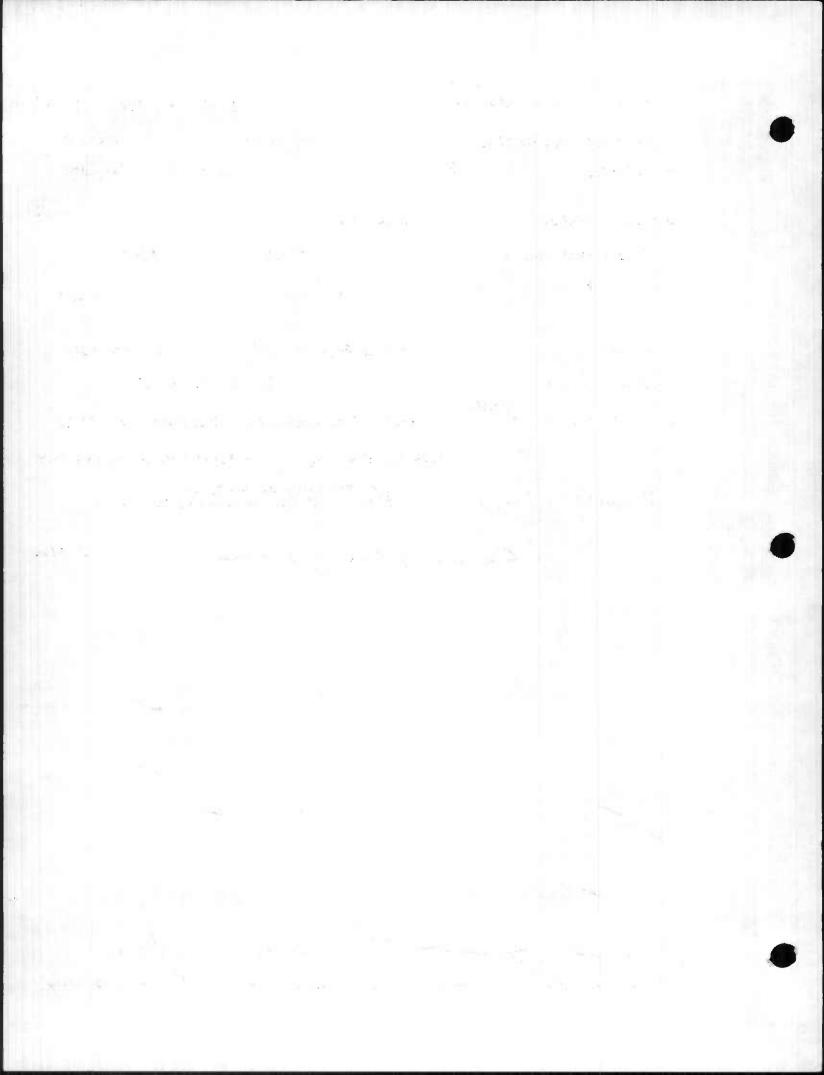
6 Could not be

3

MD 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end manner stated.



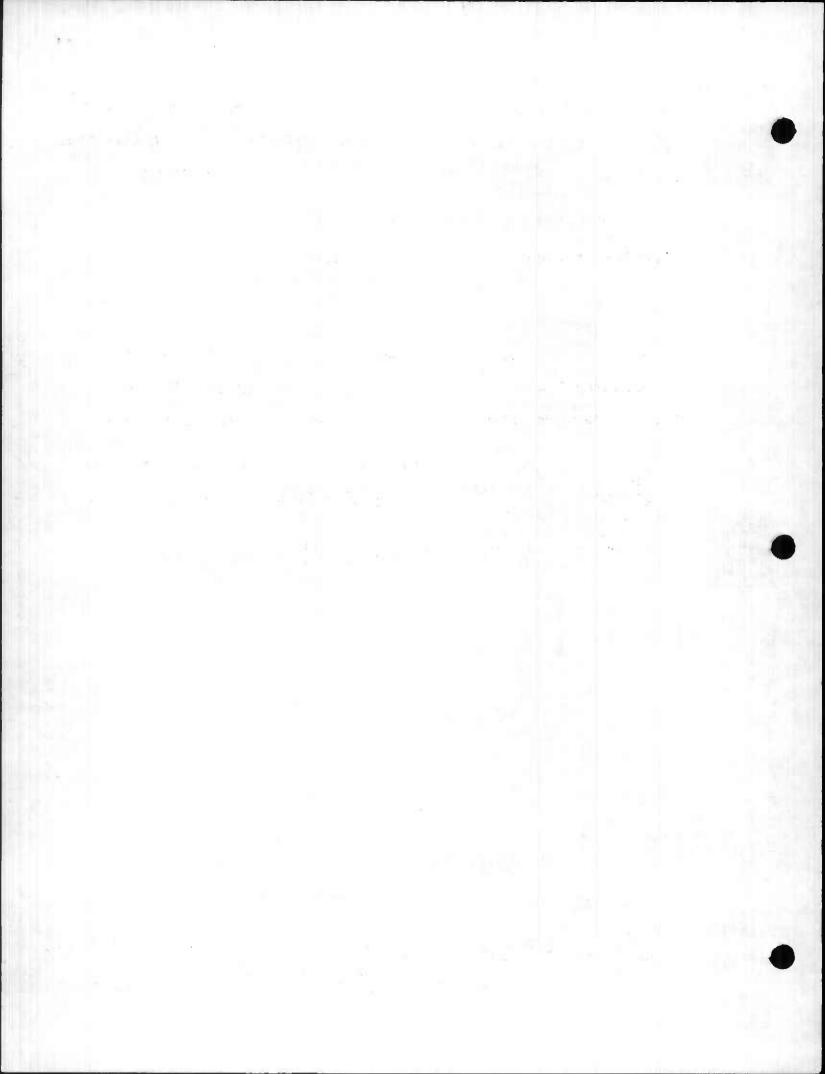
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** pm 4035 21,1599 Smue Marc /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Baltimore Baltimore Medical Center Towson Greater If Under 1 Yeer Months Days If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 6 Sex 9. Birthpiace (State or Foreign **Funeral** 100M 20 F Hours Min 60 Director 213-38-6366 March 24 1938 MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiene.

Important: If Rem 27 is marked other than "naturel", or items 23s or 28s-f show any Injury or other traumstic event, the Medical Examiner found by notified at 10c. City, Town or Location 10a Stete 10b County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Baltimore Monkton 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 15608 Irish Avenue Funeral 21111 USA 14. Race - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2□No Specify: Specify: White by 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Farming 8 Farmer n/a 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ross Leroy Ensor Zora McClung Billingsley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Karen E. Beall/daughter 2601 Corbett Rd., Monkton, MD 21111 20b. Place of Disposition (Name of cametery, cremetory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jessops Meth. Ch. Cem. 3/24/99 Sparks, MD of Funeral Service Ligan Lemmon Funeral Home
10 W. Padonia Rd., Timon

23a. Part1. Enter the Idisease, or complication, that caused the death. Do not enter the mode of dying, auch as cardiac or respiretory arrest, shock, or heart failure. List only one cause on mode line. Timonium, MD 21093 Approximate fnterval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cardio Vascular Disease Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executions) Due to (or as a consequenca of): physician Division of Vital Records, P.O. Box 68760 Physician/Medical 96 Due to (or as a consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? 3 Probably 4 Donknown B 1 Yes 2 No signed d be det à 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? contificate has i 1 Yes 2 No 2 No 25. Wes case referred to medical examiner?

1. Yes 2 No Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Inpatient 2 DENOutpatient 3 DOA # Certification: 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Attending Affar 5 Pending investigation 1 Waturei 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) aher 4 Homicide ò To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. edical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) Hamle rnellmd 1291 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 2 3 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nor 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Physician street CTIV \* /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore City If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In vrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** Hours Baltimore Months 10 M 201 None Director Usual Rasidance of Decedant the Merylend 10c. City. Town or Location 10d. Insida City Limits 10e. Stata 10b. County is 1 and 2 should be filed within 72 hours efter death with the Merylen of Health and Mentel thygiene. The terms 23s or 28s-f show other traumatic event, The Medical Examines must be not liked. 1 ☐ Yas 2 No Maryland Baltimore Baltimore County Director 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 1 Yuma Court 21133 U.S.A. Funerai 13. Was Dacedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? 11 Marital Status 1 ☐ Yas 2 ☐No If Yas, Giva 1 Navar Married 2 Married Maryland 21215-0020 Specify: Black 1 ☐ Yas 2 No Specify. ρ 3 ☐ Widowad 4 ☐ Divorced Yaar or Datas Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decadant's Education (Spacify only highast grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) None None 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Sharien Estreet Erwin Mitchell 10 Jermit. Peges 1 end 2 sh.
Department of Heelth end N.
Important: If item 27 Is many injury or other 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Yuma Court, Randallstown, Maryland 21133 Sharien Estreet/mother Baltimore. 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 □Donation 5 □Othar (Specify) In state 21. Signature of Fu ral Sarvice Licensae Wade, 22 Stated Adda to English Board, 655 W. Baltimore Street Director acae Baltimore, Maryland 21201 unun 2 a. Part I. Entar tha disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical tmmediata Causa (Final min disaasa or condition rasulting in daath) Examiner Examiner emasician end buriei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consaquance of) certificate be execu Division of Vital Records. P.O. Box 68760 physician Physician/Medical the that initiated avants rasulting in daath) Last Dua to (or as a consequanca of): 98 USB for signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown by 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy Completed peed hes pege 2 1 Yas 250 1 Yas certificete director. 25. Was casa rafarrad to medical axaminar? 26. Placa of Daath (Chack only ona) Be Hospital: Other: 4 Nursing Homa 5 Residence 6 Dother (Specify) Hospita 1 Yas 2 No 10 12 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Death 28b. Tima of Certification: Natural 5 Panding invastigation or Attending 1 ☐ Yas 2 ☐ No 2 Accidant efter deeth 6 ☐ Could not be 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 - Homicida Hospital 24 hours 29a. Cartifian 🕰 Certifying Physictan: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licansa number 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

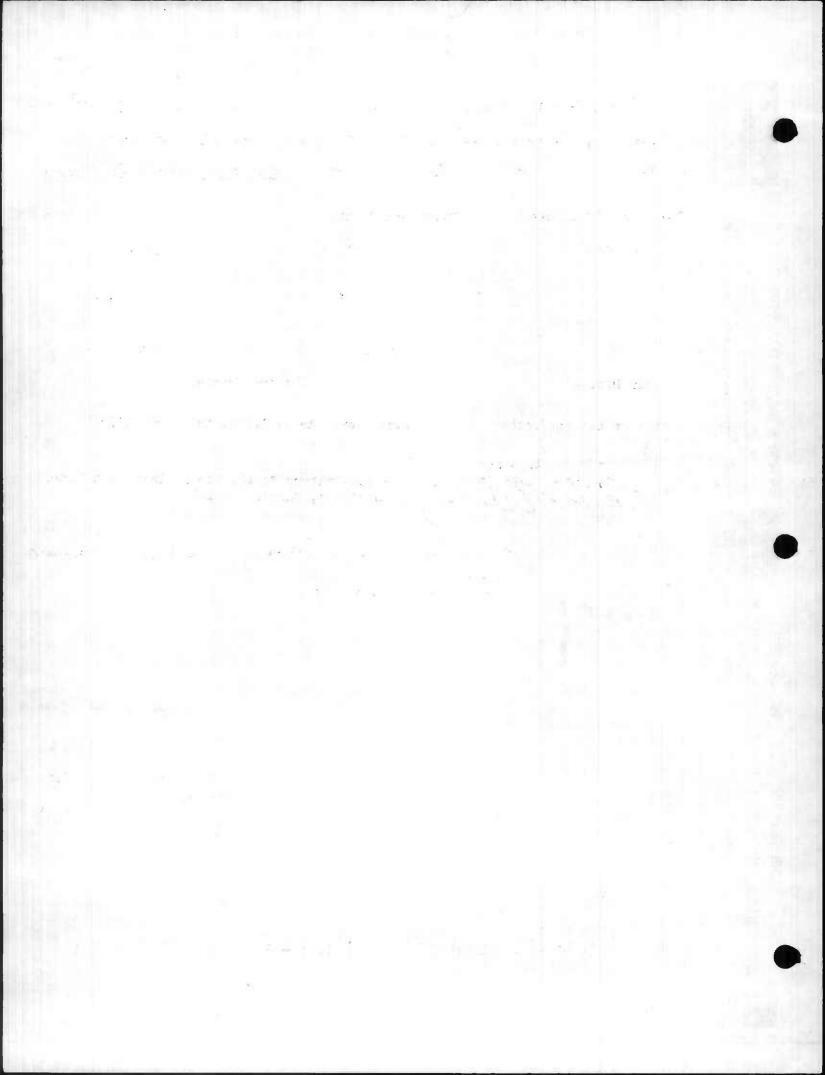
State Registrar

31. Data filad (Month, Day, Yaar) 23

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32. Registrar's Signatura

HOSPISA



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death E 9 9 ERI Month DORIS 20, 63:55 PM MARCH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Manyland Medical System BALTIMORE If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F Days 220-22-3731 Usual Residence of Decedent APRIL 2, 1921 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Llmits MD NIA BATTIMORE Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4113 Century 21206 RD U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 1 Specify. WhitE Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 th NIA School INDUSTRY TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Preston White Jennie Gelver 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Rose ANN 9612 Cross RD. BATO. NO LEARY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State PARKWOOD CEMETERY 3/24/99 BALTO. MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HARTLEY MILLER FUNEFAL Home CHTD. 21. Signature of Funeral Service Licensee Iller 23a. Pert1. EMer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Immediate Ceuse (Final disease or condition resulting in death) per roll a Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Asperation Due to (or as a consequence of): Accident Vascular Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy 1 ☐ Yes 2 XNo 1 Tyes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) npatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

Examiner

Physician/Medical

by

Completed

Be

Certification: To

Medical

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

28a-f show mant be notified at

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items 23a

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permit. Pages 1 and 2 should be file Depertment of Health and Mentel Hy, Important: If Item 27 is marked other any Injury or other treumatic event, once.

filed within 72 hours efter

Maryland

Baltimore,

treumatic event, the Medical Examiner

Director

Funeral

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pue Box 68760, physician The law requires that the death certificate be P.O. this certificate Division of Vital ai or Attending Physician: The safter death.

i Director: After this certificate of in by the funeral director, pa

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

5 Pending Investigation 6 Could not be determined 3 Suicide 4 Homicide

28e. Dete of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

AU4176435-A954

MEDICAL

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) David Alway university of Mary Cart

31. Dete filed (Month, Day, Year) MAR 2 3 1999

32. Registrar's Signature

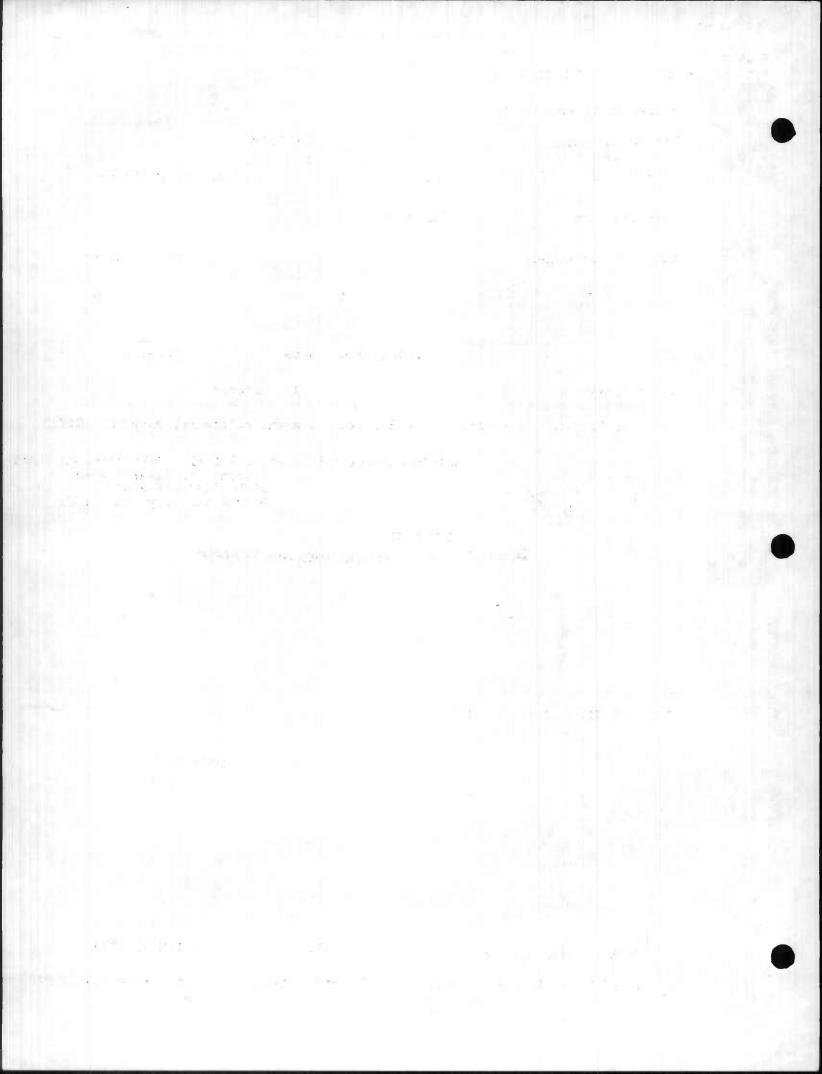
State Registrar

24 hours e

To the Hosp within 24 ho To the Fune completely f

## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

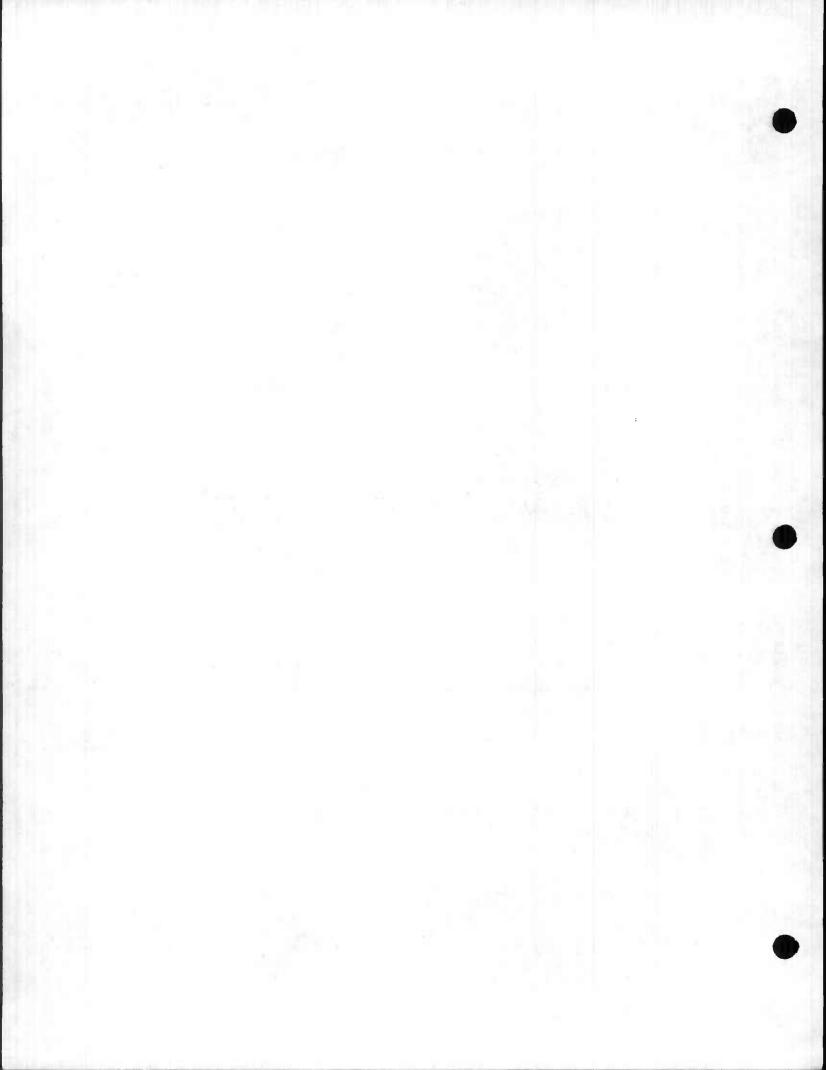
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Baltimore, Maryland 21215-0020 semili. Peges 1 end 2 should be filled within 72 hours of Department of Health and Mental Hygiene. Important: If New T2 Is marked other than "nature!, or my Injury or other traumatic asent the state of the		Doris J. Fitzsimm  20a. Mathod of Disposition  1   Burial 2 □ Cramation 3 □	Ramoval from State	20b. PI	ace of Dispos matary, cram	ition (Nama or atory or othar	placa)	e, Balti	20	c. Location -	City or To	own, Stata	
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Division of Vital Record to Attending Physician: The law require effer death.  Divector: After this certificate has been significate that the funeral director, page 2 should in the the funeral director, page 2 should	Certification:	2 Accident invastigation 3 Suicida 6 Could not be 4 Homicide datamined	28a Pinos of Injury. At home form street factors office				28f. Locati	ion (Street r Town, S	at and Numb Stata)	er or Run	al Routa Nu	m <i>ber</i> ,	
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F 3 F 8		> 1/0/4 - 0	011.00				C.M.E.			RCH 13			
		30 Name and address of parents	YILLU STORE	doath /lear	23a) /Time F		· C · 11 · E ·		1.17-71		, 100		
9 666		HAMPAMAN	D Love	My	American		enn Stre	et, Balt	timo	re, Ma	ryla	nd 21	201
	State istrar	31. Data filad (Month, Day, Year)	Car person	rai's Signet	0. A	DESKS							



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

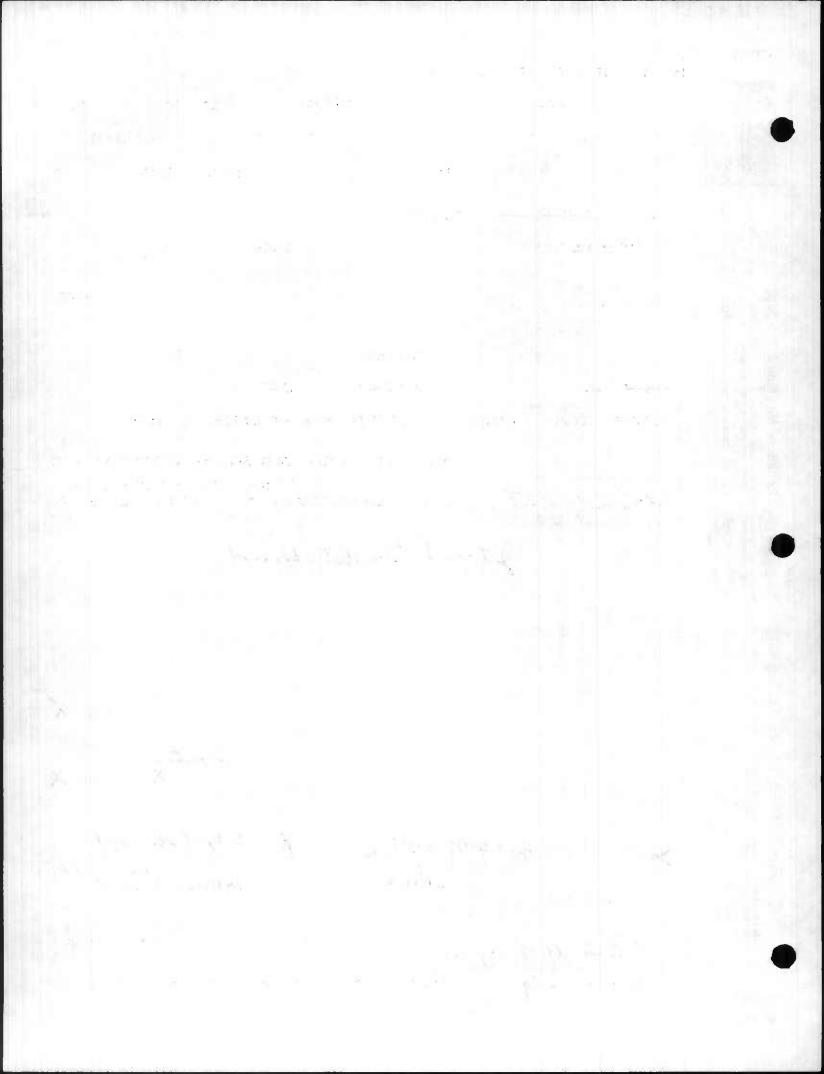
	Certificate of Death	ר	Reg. No.	0 0 0 0 0		
	1. Decedent's Name (First, Middle, Last)	2. Date of Month		3. Time of Death		
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cai ner		own, or Location of D				
Ģ1	Huly causs Huspital Silve	ex spring	make	tgo nexy		
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under					
	577-04-5447 10 M 2□F 77 Yrs. Months Days Hours Usual Residence of Decedent	Min. (Month,	Day, Year)	Birthplace (State or Foreig Country)		
	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limit		
ğ	MD Montgomeny Cilver Spring			1 Yes 2□N		
3	10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	nt Country?		
by runeral Director	mD montgomeny Silver Spring  100. Street and Number  2015 East West Highway 20910		U.S.A.			
20.00	11. Marital Status リルドルロック 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica	an, Puerto Rican, etc.)		American Indian, White, etc.		
a monday	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes or Dates:	CubAN	Specify:	white		
	15. Decedent's Education (Specify only highest grade completed) UNK Good of the life. DO NOT use retired)		16b. Kind of Busin	ess/Industry		
	Elementary/Secondary (0-12) College (1-4or 5+) Unknown Attendant		PARKING	GRANGE		
	17. Father's Name (First, Middle, Last) 18. Moth	ner's Name (First, Mid	Idle, Maiden Sumeme)			
	UNKNOWN	NKNOWN				
	19a. Informant's Name/Reletionship (Type, Print)  Unknown  19b. Mailing Address (Street and Numb Unknown	ber or Rural Route Nu	mber, City or Town, Ste	ate, Zip Code)		
	20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - Cit	y or Town, Stete		
	1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)					
	4 Donation 5.5 Other (Specify) In State	N14				
	21. Signature of Funeral Service Ligarization Processor Facility Ronald S. Wade Director State Anatomy Baltimore, Mar			ore Street		
	23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such early		Approximete			
	Immediate Cause (Final disease or condition resulting in death)  Aut Mycannial Infant  Due to (or as a consequence of):	ction		Onset and Death		
	Dua to (ut as a consequence of).					
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events  Due to (or as a consequence of):  Due to (or as a consequence of):	Due to (or as a consequence of):				
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Physician	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part			bute to the cause of deat  ☐ Probably 4 Unknown		
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Completed			Vas an autopsy 2 erformed?	24b. Were autopsy finding available prior to completion of cause		
				of death?		
3		1	Yes 200 No	1 Yes 2 No		
B	examiner?	ce of Deeth (Check or	nly one)			
2		lursing Home 5 🗆 R	lesidence 6 Other	(Specify)		
Certification:	27. Manner of Death  1 X Natural  1 Pending  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?  1 Accident investigation		28d. Describe how injury occurred  28f. Location (Street end Number or Rural Route Number, City or Town, State)			
	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not ba determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
	29a. Certifier  (Check only  Check only  (Check only  (C	and place, end due to	the ceuse(s) end menn-	er es stated.		
Medical	and manner stated.					
	29b. Signature and title of certifier  29c. License number		29d. Date signed (/			
	M. S haga 011879		MARCH	16 1999		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SANKARAN NAMA MD 3117 38 AND CAHRYE ( 31. Date filed (Month, Day, Year)  32. Registrar's Signature	ty man	(1.17.2)	2		
	31 Data filed (Month Day Veer) 22 Penistrate Cincelling	MI IN HIN	ANA DIL			
ate rar	31. Date filed (Month, Day, Year) MAR 2 3 1999  32. Registrar's Signature					
el I						



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	5. Social Security UNKNO	WN	6. Sex 7. M 2□ F	. Age (In yrs. 49	root butildoy)	If Under 1 Year Months Deys			Year) , 1949	9. Birthpl Count	lace (State or Fore try) MD
Evaning must be notified at 1 by Funeral Director	Usual Residence of Decedent  10e. State  10b. County N/A  MD  ASSITTMORE CTTY  10c. City, Town or Loc BALTIMORE					ation				10	0d. Inelde City Lim
	10e. Street and N	lumber		200	TINORE	10f. Zip Code		1	l0g. Citizen of V	Vhat Count	- 1-0.0-
	6415 DORAL DRIVE #A			4			21209	9	U.S.		
11. Merital Status  1 Never Married 2 Merried  3 Widowed 4 Divorced		12. Was Deced Armed Force  1 Yes 2 If Yes, Give Year or Date	es? (XNo	lf.)	as Decedent of Yes, specify Cul ☐ Yes 2 X No	oan, Mexicen, Pue	Specify Yes or No- rto Rican, etc.)	y Yes or No- an, etc.)  14. Race - American Indian, Black, White, etc.  Specify: WHITE			
		15. Decedent ecify only highes			(Give ki	int's Usual Occu ind of work done O NOT use retin	during most of wo	orking	16b. Kind of Bu	usiness/Ind	lustry
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-	17. Father's Name (First, Middle, Last)  DANTEL SYL VAN			FRIED	MAN	LEAH	eme (First, Middle, Maiden Sumeme) HOFFMAN				
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						Name end Addr	ass of Facility	OL LEVINS			
the burial-transit				Due to (	or es e conseque		Wor	wel			
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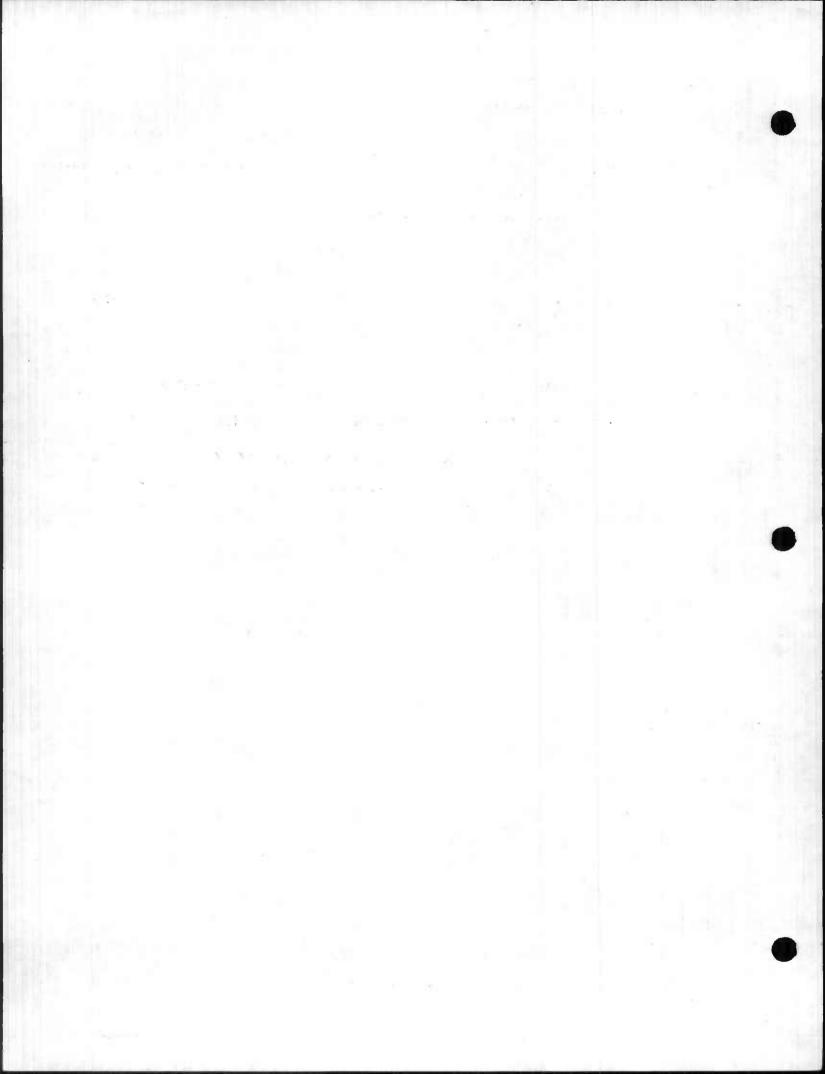
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Bea No. 99 0 9390

									Death			Reg. No.	_	
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/Medical Examiner	4a Fac	lity Nama (If not institution						4	b. City, To	wn, or Lo	cation of Death	-	nty of Death	h
-xallille!		8407 Morve	en Roa	h.	11				Par	kvil	le	Bal	timor	e
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uneral irector		5. Social Security Number 6. Sex 125 M 2 F 7. Age (In yrs. last birthday) 12 M 10 F 10 Months Days Hours						Min.	Month Da May 27	V. Year)	West	Virgini		
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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima ol Death Month **Physician** Fredenrich Regis 2:55 P.M. TARCH 18 /Medical 4c. County of Deeth 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death Examiner Rosedale SEUARE HOSVILA IER BATTIMORE en . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) PA 6. Sex 1 XM 2 ☐ F Social Security Number 285-12-0690 **Funeral** Months Days Director Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits rai', or items 23s or 28s-f show Examiner must be notified at MD Baltimore Rosedale 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1012 Chesaco Ave. 21237 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried "natural", or W II 1 Yes 2 No Specify: specify: white py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Precision Machinist Edgewood Arsenal Maryland 18. Mother's Neme (First, Middle, Meiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If frem 27 ia marked other any injury or other traumatic avent 17. Father's Name (First, Middle, Last) Be Eulla Sheldon Albert Fredenrich Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1012 Chesaco Ave, Rosedale, MD 21237 19e. Informent's Neme/Relationship (Type, Print) Doris Fredenrich / wife Baltlmore, 20b. Plece of Disposition (Name of cametery, cremetory or other 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 3-20-99 Gardens of Faith Baltimore, MD 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Bignature of Funerel Service License 1211 Chesaco Ave. Rosedale, 23a. Pert1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical . MyoCARdiA Infarction Examiner Examiner 36 Hours Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. been signe should be þ 24b. Were autopsy findings available prior to Completed 24e. Wes en autopsy performed? completion of cause of death? 20 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Neturel death. 2 Accident 1 Yes 2 No efter death Director: 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 6 hours e Hospital 24 hours 29e. Certifier 1) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. Medical (Check only one) Vithin 2 To the 29c. License number 29d. Date signed (Month, Dey, Year) 19 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

0

DHMH 16 Rev 6/95

ORIGINAL

FRANKlin

32. Registrer's Signeture

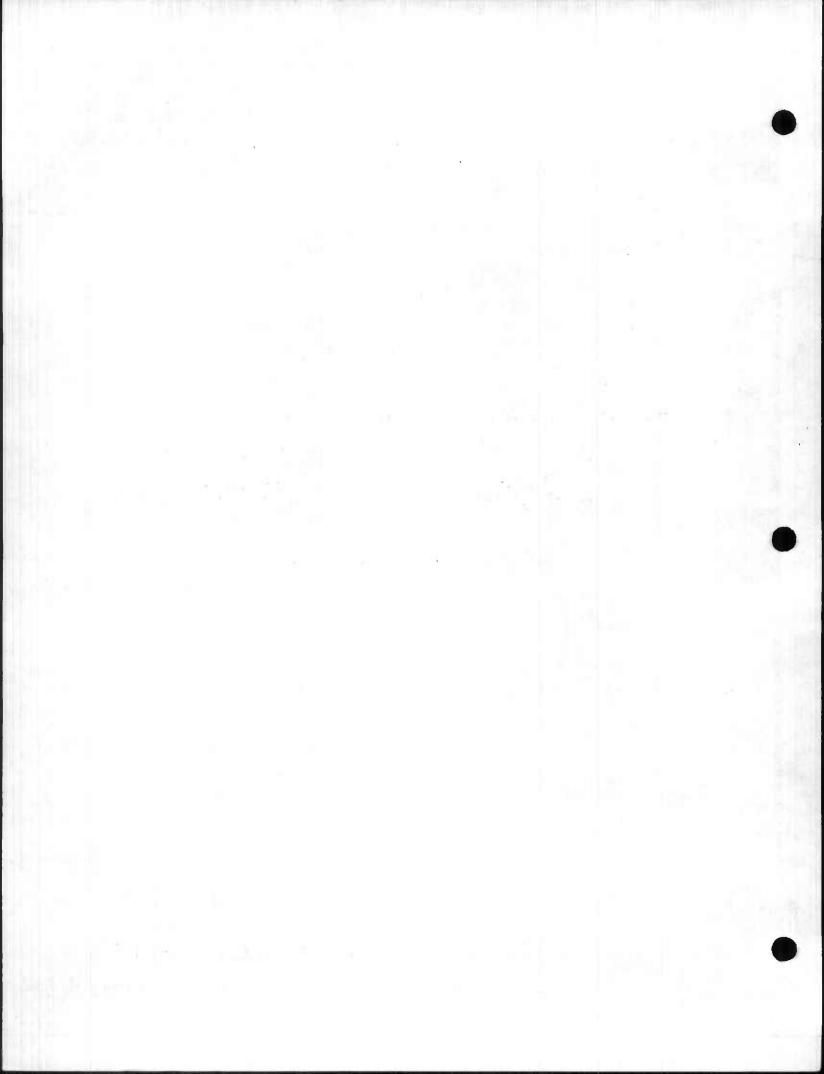
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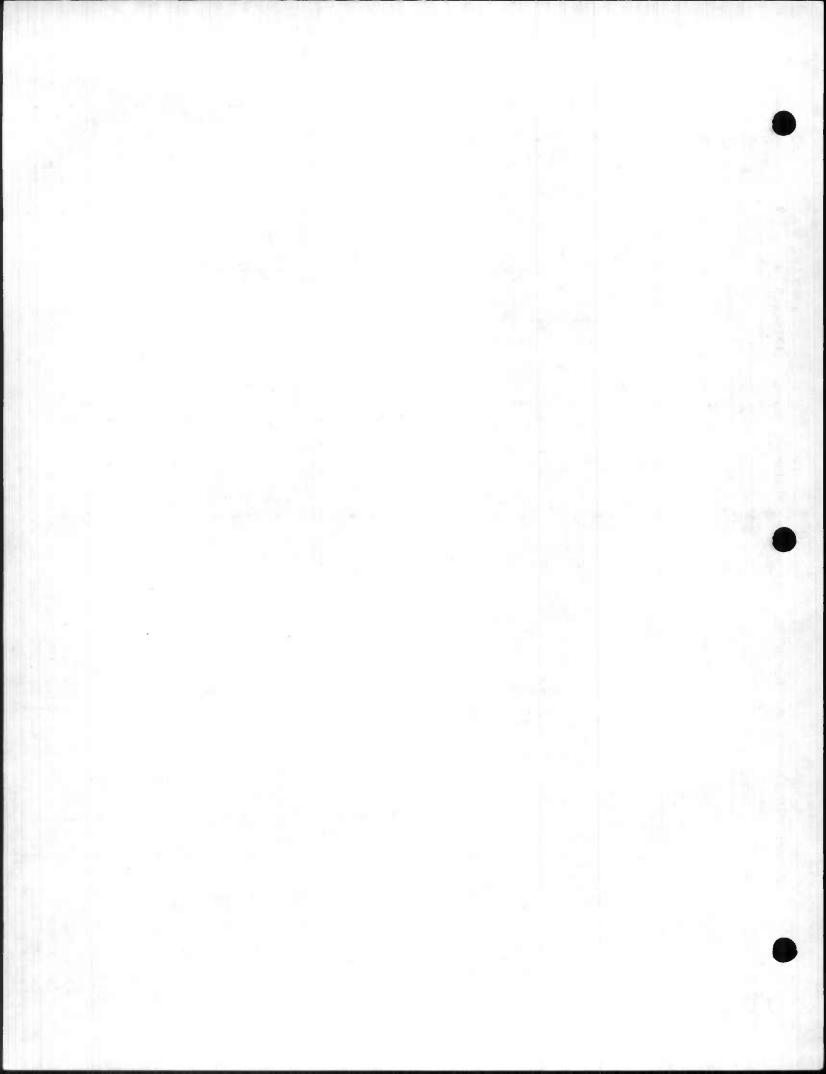
MAR 23 1999

31. Date filed (Month, Dey, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 9 3 9 2

	Certificate of Death	Reg. No.				
Physician	Decedent's Neme (First, Middle, Last)	2. Dete of Death Month Day	3. Time of Death			
/Medica	Dernard Sylvescer Frankrin, St.		999 3:15 pm			
Examiner	4a Facility Neme (If not institution, give street and number) 4b. City, Town, or I Country Home, Ltd.  Harwood					
	5. Social Security Number 6. Sex 7. Age (tn yrs. last birthday) If Under 1 Year If Under 24 Hrs.		Arundel			
Funeral Director	578-07-5775 MXM 2 F 86 Yrs. Months Days Hours Min.	Sept. 7,1912	Birthplace (State or Foreign Country)     Maryland			
ahow	10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits			
the Maryla	MD Anne Arundel Shady Side		1 ☐ Yes XXNo			
Iter deeth with the Manyland ritems 23s or 28s-f show the man be notified	10e. Street and Number 10f. Zip Code	10g. Citizen of W	/het Country?			
with w	4876 Idlewilde Road 20764	USA				
	11. Merital Status  12. Wes Decedent Ever in U,S. Armed Forces?  13. Wes Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerlo	pecify Yes or No- o Rican, etc.) 14. Race Black	e - American Indien, k, White, etc.			
2 : 0		Specify	White			
72 hours at "natural", or		16b. Kind of Bu	siness/industry			
T c 1 4 3	(Specify only highest grade completed)  (Give kind of work done during most of work file. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	King				
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Maryland 2 d 2 should be filed th and Mental Hygh 7 le merked other traumette event.		ne (First, Middle, Maiden Surnem	e)			
should Ind Menid Ind Menid Ind Menid Ind	Harry Franklin Irene  19e. tnformant's Neme/Relationship (Type, Print)  19b. Meiling Address (Street and Number or Ru		State Zin Code)			
2 8 9 8	Bernard S. Franklin, Jr. (Son) 4876 Idlewilde Road,					
other tr	20a. Method of Disposition 20b. Place of Disposition (Name of		City or Town, Stete			
0 90 - 5	1 KD Burial 2 Cremetion 3 CHemovel from State	03/30 Chelten	ham. MD			
프 교육원은	21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility		richity PiD			
Depa Depa impo	Hardesty Funeral 12 Ridgely Avenue		D 21401			
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiretory errest,	Approximete Interval Between			
Physician	1 1 1 1 1		Onset end Deeth			
/Medical Examiner	disease or condition a. left-lower when bley	morria oras	nim Week			
	Due to (or es a consequence of):	/ cukino	Pa !			
oxecuted an end rie-transit	0.	Lancier	~~)			
760, te be executed ysician end buriel-transition from the buriel-transitio	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.					
death certificate be execute attending physician and of for use as the burletra	Cause (Disease or injury that initieted events Due to (or as e consequence of):					
5 00						
ds, P.O. Box ires that the death cert signed by the attending d be detached for use						
.O. the de nother moched	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.		stributa to the cause of death?			
2 2 2 2		1 ☐ Yes 2 ☐ No	3 Probably 4 Unknown			
Records, he law requires the law requires to has been signed age 2 should be completed by		24e. Wes an eutopsy	24b. Were autopsy findings			
w require to been si should	2) Vendiation; a 20 lema	performed?	available prior to completion of cause of death?			
The law requires to be a specific base been spage 2 should Completed		1   Yes 2   100	1 ☐ Yes 2 ☐ No			
f Vital Reystein: The law ystein: The law lis certificate has director, page 2	25. Wes case referred to predical 26 Place of Det	ath (Check only one)				
Of Vita Physician: this certific and director.	Hospitel:   I Innetient 2 FR/Outpetient 3 DOA Other: APAluming H	lome 5 ☐ Residence 6 ☐ Othe	er (Specify)			
ng Pl	27. Manner of Death 1 ☑Netural 5 ☐ Pending (Month, Day Year) 28b. Time of 28c. Injury et Work?	28d. Describe how injury occurr	ed			
VISION Attending or death. ector: After by the fune	2 Accident investigation 3 Suicide 6 Could not be	Opt Leasting (Chantend Must	and Don't Bouts Must be			
Division of attending P at or Attending P at or Attending P at or Director: After to led in by the funeration:	4 Homicide  4 Homicide  4 Homicide  28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number City or Town, State)	or Murer Houte Number,			
Mospital Manager Funeral Hay filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place	and due to the cause(s) and me	nner as stated			
Division  Othe Heaptal or Attending is within 24 hours after death. To the Funce Director After completely filled in by the fune Medical Certification	Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurrent.					
Division o To the Heapttal or Attending Ph within 24 hours after death. completely filled in by the funeral Medical Certification:	29c. Sanature and title of partifier 29c. License number	29d. Date signed	(Month, Day, Year)			
	Mellet Mullan Im D11653	Mar	1622 00			
	3d / same and address of person who completed cause of death (ttem 23a) (Type, Pript)	1 10				
\	July Verkouw 2003 Med Falleway	Amagolis, a	MD 21401			
State Registrar	31. Date filed (Month, Dey, Year)  MAR 2 3 1999  32. Régistrar's Signeture	0				



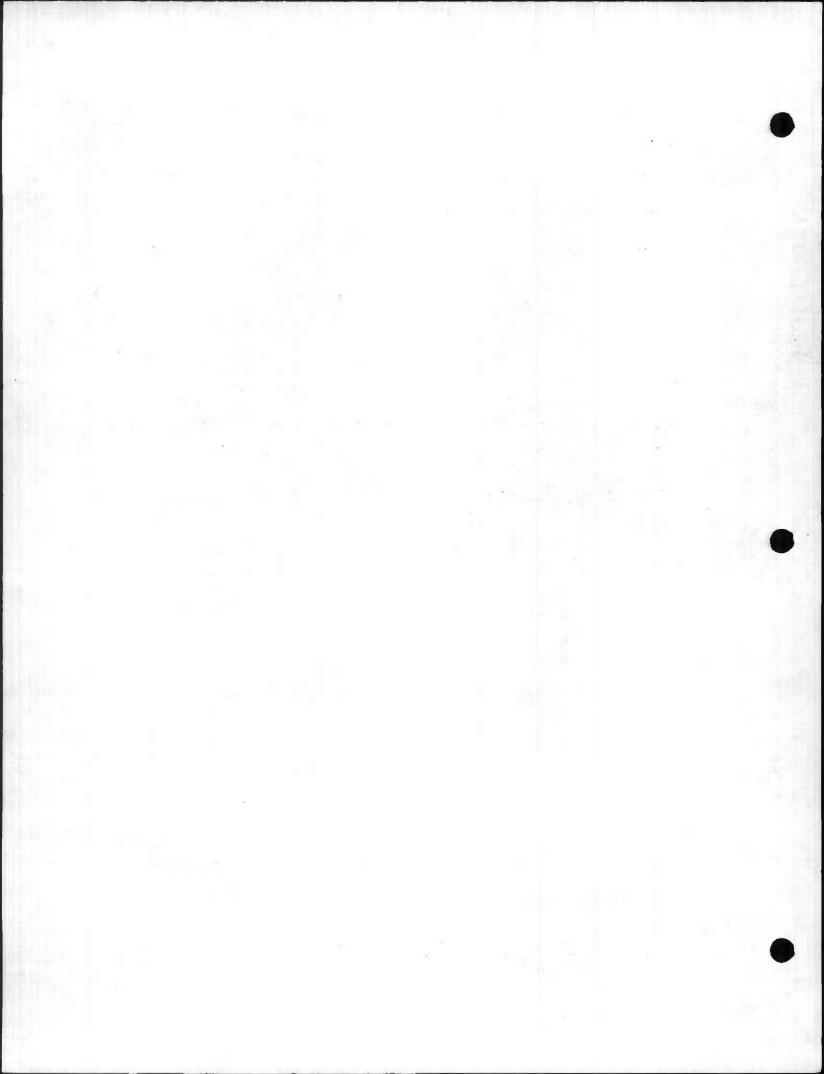
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State of Maryland / Department of Health and Mental Hygiene O

	1. Decedent's Name (First, Middle, La	st)	Ce	rtificate of	Dealii	2. Data of De		3. Time of Dea			
Physician	Donald Web					Month March	Dey	Year 999 6:10 F			
/Medical	4a Facility Name (If not institution, give					Location of Deat					
Examiner	15200 Priceville		Baltimo								
Funeral	5. Social Security Number 6. S		yrs. last birthday	If Under 1 Year							
Director	220-62-3231 Usual Residence of Decedent	X 20 F 45	V	Months Days	Hours Min.	Dec. 3		Birthplace (State or Fo Country)     MD			
ms 23a or 28a-f show remail be notified at neral Director	10a. Stete 10b. County  MD Baltimo		c. City, Town or L Sparks	ocation	1 - 31			10d. Inside City L			
or 28e-f s be notified Director	10a. Street and Number		-  -  -  -  -  -  -  -  -  -  -  -  -  -	10f. Zip Code	20 10 10 10		10g. Citizen of W	hel Country?			
Name 23a or 28e-f show the matter notified at Uneral Director	15200 Priceville				21152		USA				
natural, or hams 23s dical Examination must eted by Funeral	11. Manitel Status	12. Wes Decedent Ever Armed Forces?	in U,S. 13.	Wes Decedent of If Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer	specify Yes or No to Rican, etc.)	14. Race Bleck	- American Indien, c, White, etc.			
by B	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 () (Vo If Yes, Give Year or Dates:		1□ Yes 2□XNo	Specify:		Specify:	White			
"natural".	15. Decedent's E	ducation de completed)	dent's Usuel Occu	pation during most of wo	rkina	16b. Kind of Bus	siness/Industry				
t, the Medical	Elementery/Secondery (0-12)	College (1-4or 5+)	ollege (1-4or 5+)				Restau	want			
	12 17. Father's Neme (First, Middle, Last,	n/a	Ch	e1	18 Mother's Na	me /First Middle	Maiden Sumame				
o Be	Earl Fisher				Carol C		,				
The same	19e. Informent's Neme/Relationship (	Type, Print)	19b. Mai	ing Address (Stree	t and Number or Ri	ural Route Numb	er, City or Town, S	State, Zip Code)			
127 in	Mrs. Donald W. F	isher/Wife	152	00 Price	ville Rd.	, Spark	s, MD 21	1152			
aft.	20e. Method of Disposition		Ob. Place of Disp	osition (Neme of metory or other pla	ice)	Date /22 /00	20c. Location - (	City or Town, State			
ortant: If injury or 8.	1 XBurial 2 Cremetion 3 C 4 Donelion 5 Other (Specif				ng House	/23/99 Cem.	Sparks	s, MD			
portant: y injury ios.	24 Signature of Bused Service Licer		7 2	2. Name end Addr	ess of Facility		•				
TES C	Lowell M. Lon	mon mone	w		Funeral F adonia Ro		nium, M	D 21093			
	23a. Part1. Enter the disease, or com shock, or heert teilure. List only	plications thet caused the	death. Do not er					Approximete Interval Betwee			
sician edical miner	Immediate Cause (Final disease or condition Market ab its Man of Luna Onset at										
2.0	resulting in death)  Due to (or as a consequence of):										
in and ial-transit Examiner	b										
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С.									
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se as											
otte for u						1		tribute to the cause of d			
signed by the attending d be detached for use as d by Physician/Me	Pert II. Other eignificant conditions of	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.									
d be d						040 14400	an autopsy	24b. Were autopsy findi			
page 2 ahouid page 2 completed						perfe	ormed?	available prior to completion of caus			
⊕ N DL								of death?			
certificate has rector, page 2 b Be Comp	05.11					10		1 ☐ Yes Q ☐ No			
irector lirector O Be	25. Wes case referred to medical axamine ?  1 Yes 20 No	Hospitel:	•C.500		her	ath (Check only					
raidi di ATC	27. Menner of Death	1 ∐ Inpatient 28a. Date of Injury	2 ER/Outpatie	M 3LI DOA	4 ☐ Nursing F		dence 6 Othe				
tion the	Neturel 5 Pending investigation	(Month, Day Ye		Wo	ork? ]Yes 2 □ No	200.000.00	non injury coounc				
al Director: After and in by the funer ed in by the funer Certifications	3 Suicide 6 Could not b		At home, ferm, si pecify)	reet, fectory, office		28f. Location ( City or To	Street and Numbe wn, Stete)	er or Rurel Route Number			
To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certificationy To Be Com	29s. Certifier Certifying Ph	ysician: To the best of my niner: On the basis of exa	/ knowledge, dea	h occurred at the t	ime, date and place	a, and due to the	cause(s) and mer	nner es stated.			
To the Funeral Director: A completely filled in by the funeral Medical Certification	one)	and manner stated.	IIIII AUTON AND IN			med at the time,	oate end place, e	no dua to the cause(s)			
To the total	29b. Signature and title of certifier	011.	m	29c. Licen	se number	/	29d. Dete signed	(Month.)Day, Year)			
	1) Icuando	- Husul	Je )	15	1100	1	2/2	4144			
	30. Name and eddress of parson, who	completed cause of fleath	(Item 23a) (Type	Print)	SUITE	-307	Toux	n month			
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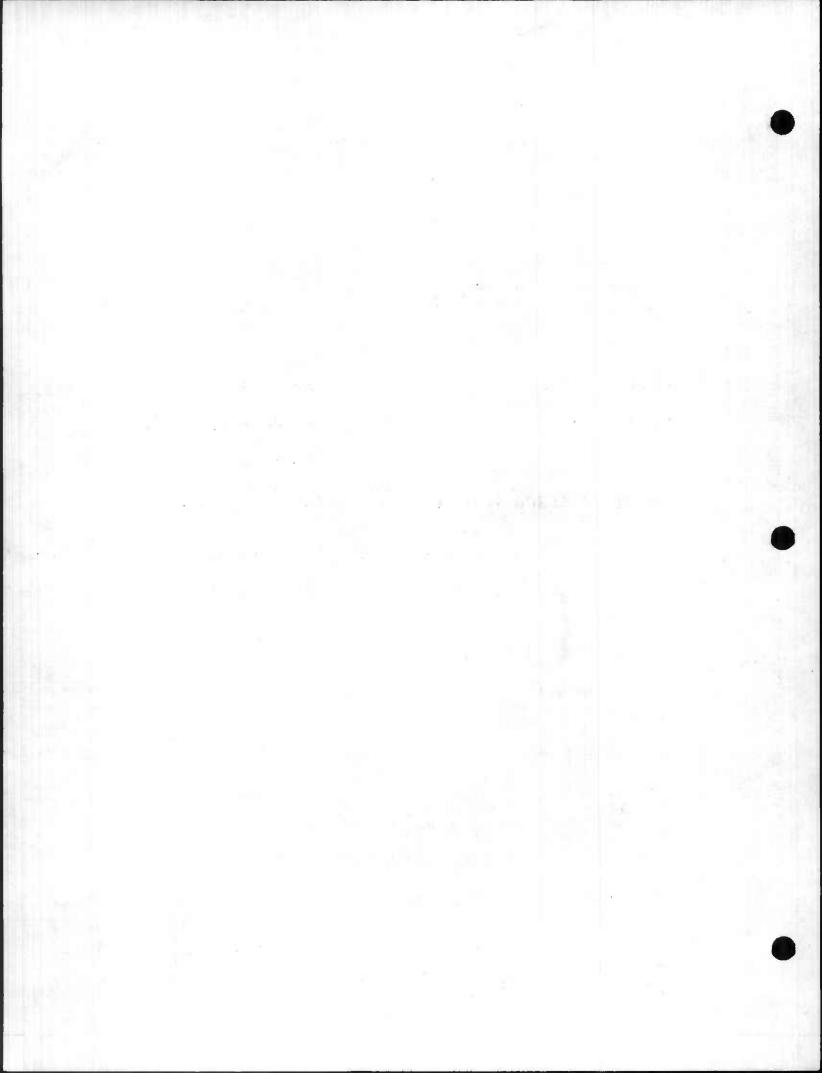
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Baltimore	
Division of Vital Records, P.O. Box 68760,	

			State of Mary		artment of h rtificate of		ental Hygien Reg. N	27.	9391	1
	Physician /Medical							ay Yes	3. Tima o	of Death 8 PM.
	Examiner Funeral Director	4a Facility Name (If not Institution,  FRANKLIN S G 5. Social Security Number 219–22–1392	WARE HOS	PITAL yrs. last birthday, Yrs.		4b. City, Town, or Local Research Section 15 Hours Min.	B. Date of Birth (Month, Day, Year September 2)	B A C 9. E 1929 FL	TIDOR	or Foreign Marylan
	2 .	Usual Rasidence of Decedant  10a, Stata  10b. County	100	c. City, Town or Le	nonting				10d. fnside (	
	f sho	Maryland Baltimore		altimore G						s 2 No
	or 28a-f be notifie Directo	10e. Sfreef and Number	10g. C	Country?						
	13a or at be	1342 Evering Avenue		21237		USA	IISA			
21215-0020	ours after death with the Marylar et, or thems 23s or 28s-f show Examiner, mark be notified at by Furneral Director	11. Marital Status  1 □ Nevar Married 2 ☒ Marrie  3 □ Widowed 4 □ Divorced	12. Was Decedent Evar Armed Forces? 1 1 Yes 2 No If Yes, Give Yaar or Dates: 190		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2XXNo	Hispanic Origin? (Spe an, Mexicen, Puerto i Specify:	cify Yes or No-	Black, W	merican Indian, hite, etc. White	
5-0	ed within 72 ho ygene. yrgene. rt, the Medical.	15. Decedent's (Specify only highest			dent's Usuai Occup	pation during most of working		Kind of Busine	ss/Industry	
121	mple and	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)				
d 2		10 17. Father's Name (First, Middla, La	N/A	Truck	Driver	18. Mother's Neme	(First, Middle, Maide	h & Solo	mon Co.	
lan	id be fi	Clarence John Fitch				Anna B. Mil		,		
ary	M bo	19a. Informant's Name/Relationship		19b. Maili	ing Address (Street	and Number or Rura		or Town, State	a, Zip Code)	
S	affin a 27 to a trans	Betty I. Fitch (Wife	2)	1342 1	Evering Ave	nue Baltimo	re. Marvland	21237		
more	10 H P P P P P P P P P P P P P P P P P P	20a. Method of Disposition		Ob. Place of Dispo				Location - City	or Town, Stete	
im	Pag ment: If ury o	1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Cardens of	Faith Man	ch 24, 1999	Balt	imore, M	arvland	
0. Box 68760,	at the death certificate be executed day the attending physician and etached for use as the burial-transit Physician/Medical Examiner	23a. Part1. Enter the disease, or coahock, or heart tailure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last	a. VENT  Due  b. MYOC  Due  c. Due	death. Do not en  RIC UC  to (or as a consect to (or as a consect to (or as a consect	ter the mode of dying the first the mode of dying quence of):  Quence of):	TACHY FARC	respiratory arrest.		Approximation interval Be Onset and	Property of Death
P.0	by the						The state of the s			Unknown
Records,	law requires the has been signed be dispendible of mpleted by						24a. Was an aut performed?		b. Were autopsy available prior completion of of death?	r to ceuse
of Vitai	certificate rector, pag	25. Was case referred to medical				26. Place of Death		210 No	1 Yas 2	_ 140
>		axaminer?	Hospitaf:	2 ER/Outpatie	nf 3 DOA Ot	her:	na 5 Residence	6 □Other (S	pecify)	
Division o	if or Attending Physical Control of the funerior: After this of in by the funeral discrification: Terminate of the funeral of	27. Manner of Death  1. Neturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Yes	28b. Time of Injury	Wo		28d. Describe how inj			
DIVIS	Lai or Attending P rs after death. al Director: After t led in by the funeri Certification:	3 ☐ Suicide 6 ☐ Could no determin	28f. Location (Street a City or Town, Sta		Rural Routa Nu	mber,				
	within 24 hours a within 24 hours a To the Funeral I completely filled	29a. Certifier Contifying (Check only one)	Physician: To the best of my aminer: On the basis of examiner stated.	rknowledge, deet mination and/or in	h occurred et the ti vestigation, in my o	me, date and place, a opinion, deeth occurre	and due to the cause( ad at the time, date a	s) end manner nd place, and d	es stated. due to the ceuse	(s)
	within To the Com	29b. Signature and title of certifier  30. Name and address of person with	occumpleted cause of death	(Item 23a) (Tuna	29c. Licens	# 1888	21 3	2010	Onth, Day, Year)	
	State	GERRI DAUI 31. Date filed (Month, Day, Year)	S 77. 90  32. Registrar's S	soo FR	ALKLIK	SQUA	er DR. C	3 ALTO	100 2	1237
	Registrar	MAR	3 1999	wa /	9. pp	reto)				

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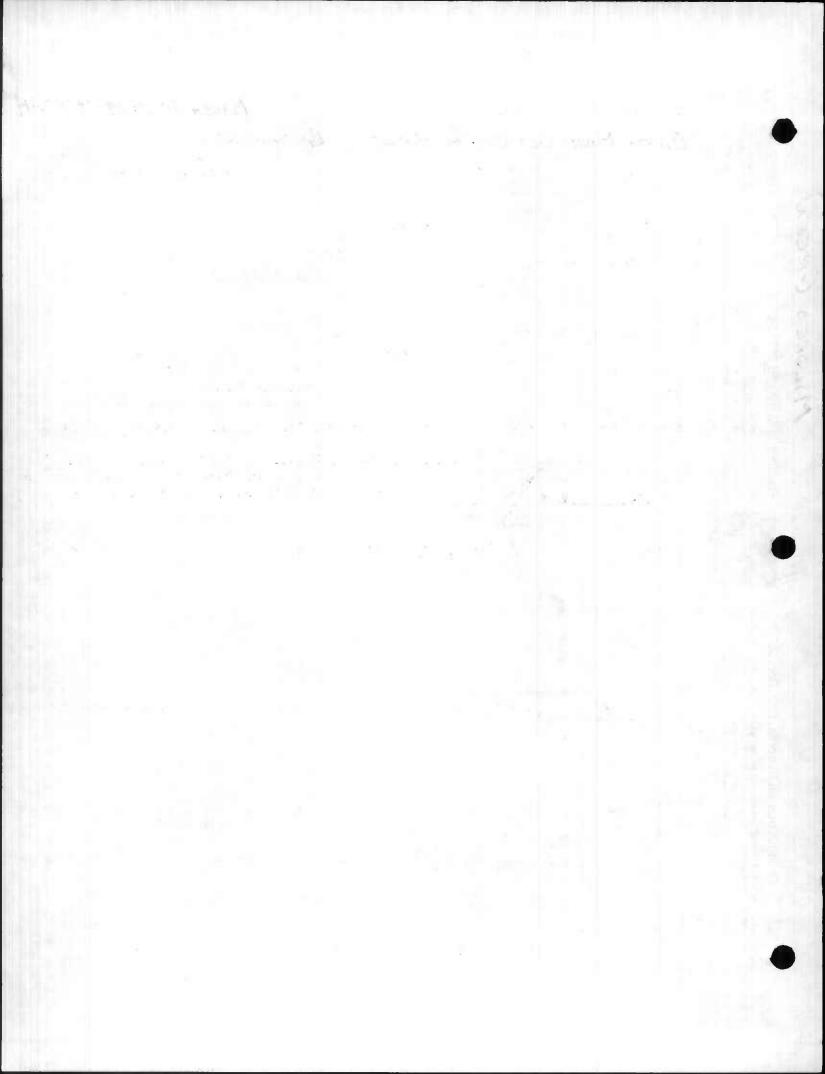


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:00A1 GREEN MILDRED V 20 MARCH /Medical 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner CATON MANOR GENESIS ELDERCARE BALTIMORE CITY If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 KF Days 218-30-5984 08/04/1911 Director North Carolina Usual Residence of Decedent 10d. inside City Limits the Meryland 10a State 10b County 10c. City. Town or Location 1 Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or treumatic event, the Wadinal Exercises must be 21229 U.S.A. Funerai 72 hours after death 6 North Kossuth Street Wes Decedent Ever in U.S. Armed Forces?

1 Yes X No If Yes, Give Year or Dates: 14. Rece - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Black by 3 X Widowed 4 □ Divorced MILDRED Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) Domestic Housekeeping 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 1 end 2 should be f Health and Mental h Victoria Johnson Willey Walton 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a Pages 1 en nent of Healt nt: If Item 27 v or other tr 6 North Kossuth St., Baltimore, Maryland 21229
lace of Disposition (Name of Date 20c. Location - City or Town, State Rosalie Moore / Daughter 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 1 Burial 2 Cremation 3 Remove from State permit. Page Department of Important: If eny Injury or poose. King Memorial Park Cem. 4 Donation 5 Other (Specify) 03/24/99 Woodlawn, Maryland 22. Name end Address of Fecility The Derrick C. Jones Funeral Hm. 21. Şignature of Funerai Service Licensi 4611 Park Heights Ave., Baltimore, Maryland 21215 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one caused the deeth. Approximete Intervel Between Onset and Death **Physician** NEUMONIA immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examin physician and the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): death certificate be exect P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): 88 esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. à 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificata has b 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 1 Naturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 24 hours Certifying Physicten: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steled.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steled. 29a. Certifier edicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Attending Doctor D21684 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C-V-CYRIAC-M-D 8109 RITCHIR UNIT, PASADENA, MO 21122 C-V-CYRIAC. M.D 31. Dete filed (Month, Dey, Year)
MAR 2 3 1999 32. Registrar's Signature Registrar **DHMH 16 Rev 6/95** 



ANTHONY GRIFFIN

### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

**Physician** /Medical Examiner 1. Decedent's Name (First, Middle, Last) ANTHONY GRIFFIN SR.

4a Fecility Neme (If not institution, give street and number)

2. Date of Death 19,1999

MARCH

4b. City, Town, or Location of Death BALTIMORE

3. Time of Death 9:27P.M.

2100 BLK. PENNSYLVANIA AVE 5. Soclei Security Number 1 M 2 □ F 212-76-5303

If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Days 28 Yrs

Birthplace (State or Foreign Country)
 MD

**Funeral Director** 

with the Maryland r 28a-f show Directo Examiner must be r Pages 1 and 2 should be filed within 72 hours efter death nent of Health end Mentel Hygiene. Funeral þ "naturel", the Medical Completed

other

Destruction

Health tem 27 is

item 2

permit. Pages Department of Important: If it any injury or o

Be

P

Usual Rasidance of Decedent 10b. County N/A

10c. City, Town or Location BALTIMORE

10g, Citizen of What Country?

USA

4c. County of Death

N/A

1 Yes 2 No

10d. Inside City Limits

10e. Street and Number 4718 GARRISON BLVD.

10a. State

MD.

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorcad

12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+) -016a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

21215

16h Kind of Business/Industry

Elementary/Secondary (0-12) -12-

LABORER

10f. Zip Coda

SANITATION

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname) LINDA SMITH

ALFRED J. GRIFFIN

19a. Informant's Name/Relationship (Typa, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code)

KIESHA N. GRIFFIN (WIFE)

20b. Place of Disposition (Name of cematery, crematory or other p

4718 GARRISON BLVD. BALTIMORE, MD 21215 20c. Location - City or Town, State

20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State

KING MEMORIAL PARK

3-25-99 BALTIMORE, MARYLAND

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MD 21217

Unevell

Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failura. List only one cause on each lina.

Approximate Interval Between Onset and Death

Immediate Causa (Final disease or condition rasulting In death)

Due to (or as a consequence of)

Due to (or as a consequence of):

Due to (or es a consequenca of):

/Medical Examiner and I-transit the death certificate be executed

physician ar

signed by the a

certificate has t lirector, page 2 s

this funeral

After Attending

in 24 hours.
the Funeral Director filled in by the

To the Hosp within 24 hor To the Fune completely fi

death.

that

law requires

Physician:

8

95 esn

Division of Vital Records, P.O. Box 68760.

Examiner

Physician/Medicai

by

Completed

Be

To

Certification:

Medical

**Physician** 

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disaase or injury that initiated events resulting in death) Last

Part If. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death?

2/1 No 1 Yes

3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings evailable prior to completion of cause of death?

26. Place of Death (Check only ona)

25. Was case referred to medicel examiner? XYes 2 No

27. Manner of Death 5 Pending

6 ☐ Could not be datarmined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b Time of 19

28c. Injury at Work? 2/1 No 1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 MOther (Specify) SCENE 28d. Dascribe how injury occurred Shot

Location (Straat and Number or Rural Route Number, City or Fowp, State) 2100 BIF

29s. Certifier cone)

1 Naturai

2 Accident

3 ☐ Sulcida

4 Demicida

1 Certifying Physicien: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

arm, streat, factory, office

290. Signature and title of certified

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) MARCH 20, 1999

and address of person who completed cause of death (Item 23a) (Type, Print)

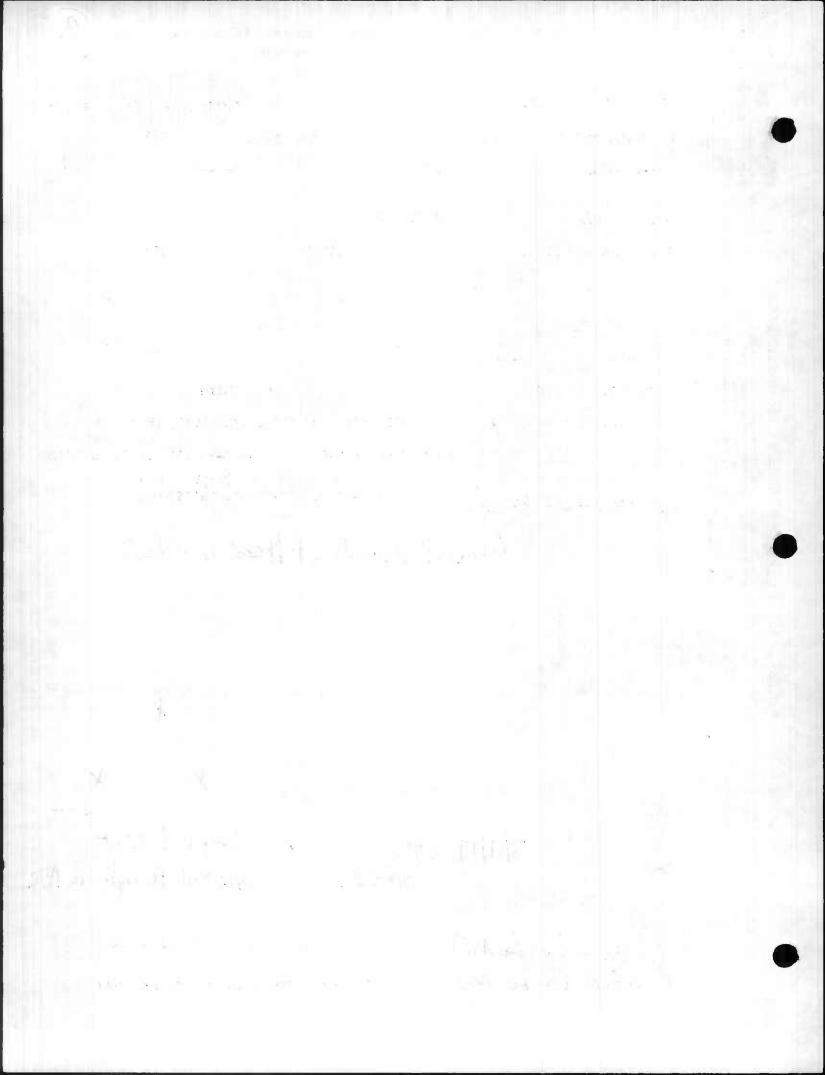
-0N 31. Dete filed (Month,

mo 32. Registrar's Signatura

111 Penn Street, Baltimore, Maryland 21201

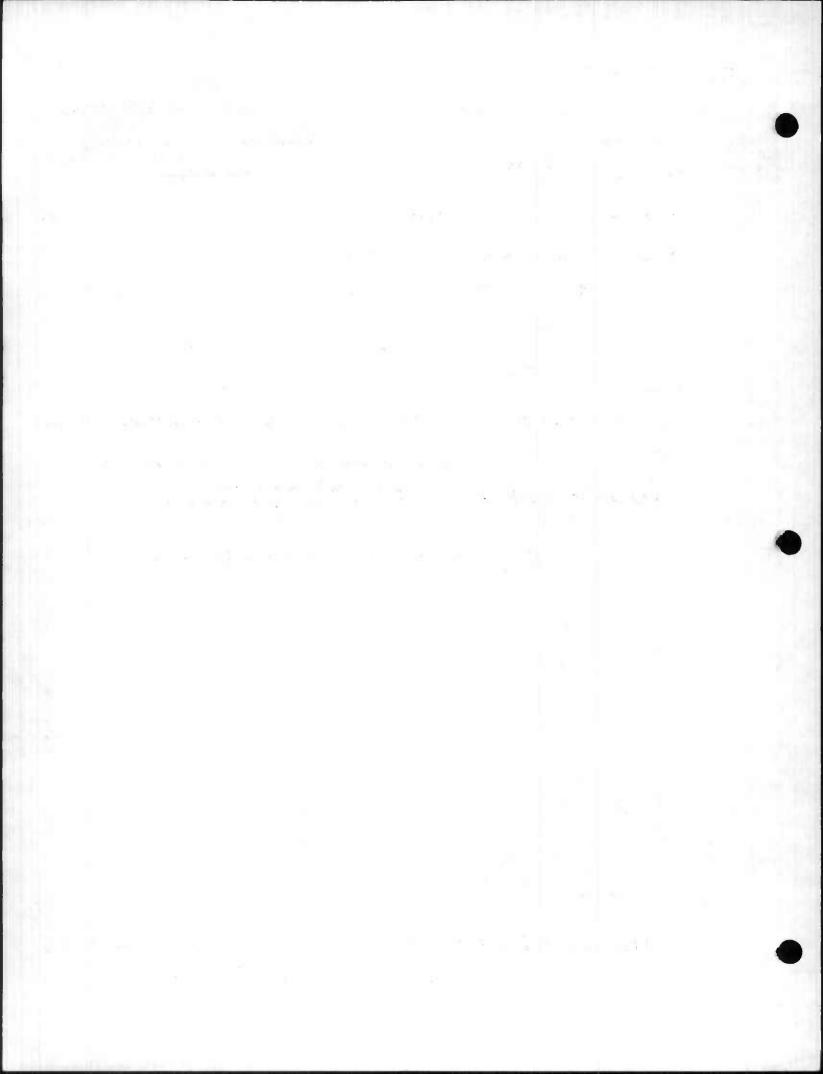
State Registrar





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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month CAROLYN. GAUSE 9:42 AM. MARCH 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death SAMARI7AN FORPITAL BACTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 7, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD • 1□M 2⊠F Months Yrs. 213-30-1827 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 129 Warwick Drive 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ 12 Teacher Christian Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Vernon E. Cook Catherine E. Miller 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Gause (husband) 129 Warwick Drive Lutherville, MD. 21093 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem, Grdns 3/23/99 Timonium, MD. 21. Squature of Funeral Service Licensee Dennis C. Carrolles. Name and Address of Facility Ruck Towson Funeral Home, Inc. anal 1050 York Rd. Towson, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but a mean failure. List only one cause on each line. Immediate Cause (Final ACUTE MYOCARDIAC INFARCTION. 3 DAYS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown STAGE RONAL DISEASE. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1□ Yes 2 DM 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records. death. after death e Hospital on 24 hours af To the Hosp within 24 hor To the Fune completely fi

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

7 is marked other than "natural", or items 23a or 23a-1 show traumatic event, tre Medical Exatraner must be notified at

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Baltimore,

State Registrar DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

ANUS

29b. Signature end title of cartifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

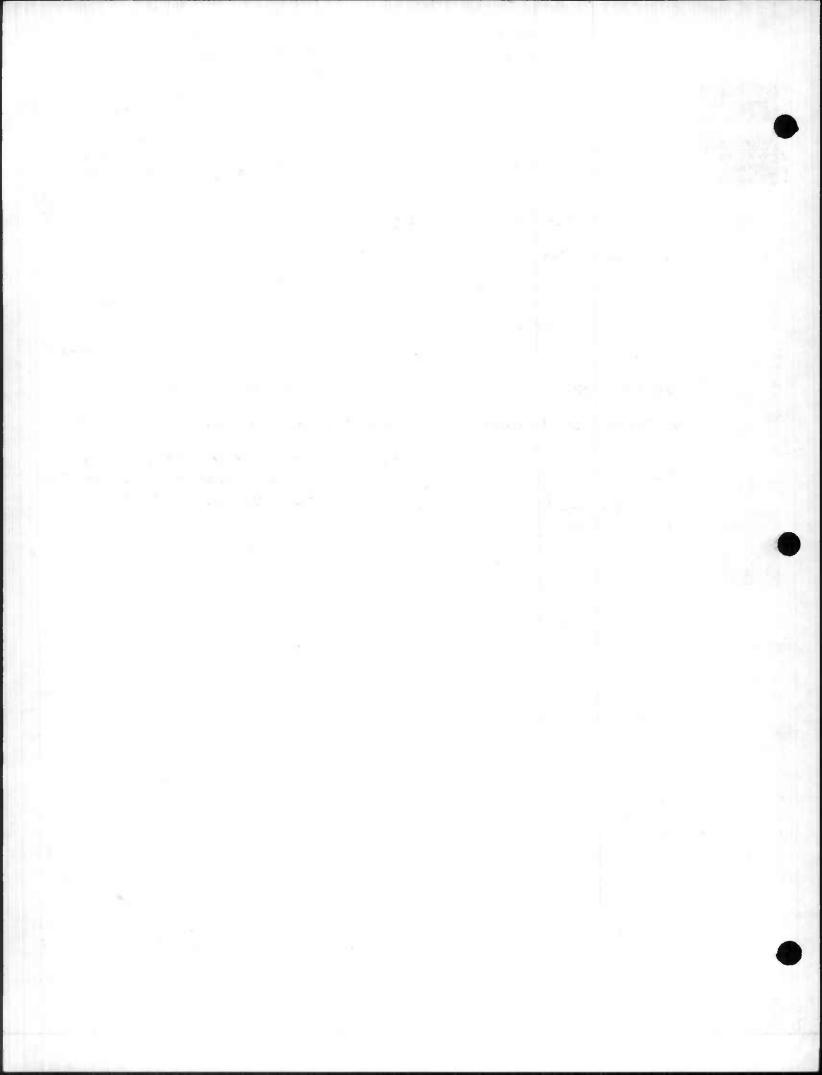
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29d. Date signed (Month, Day, Year) MARCH 19, 1999

SAMARUAN HOSP BALTIMONE.

MAR 23 1999

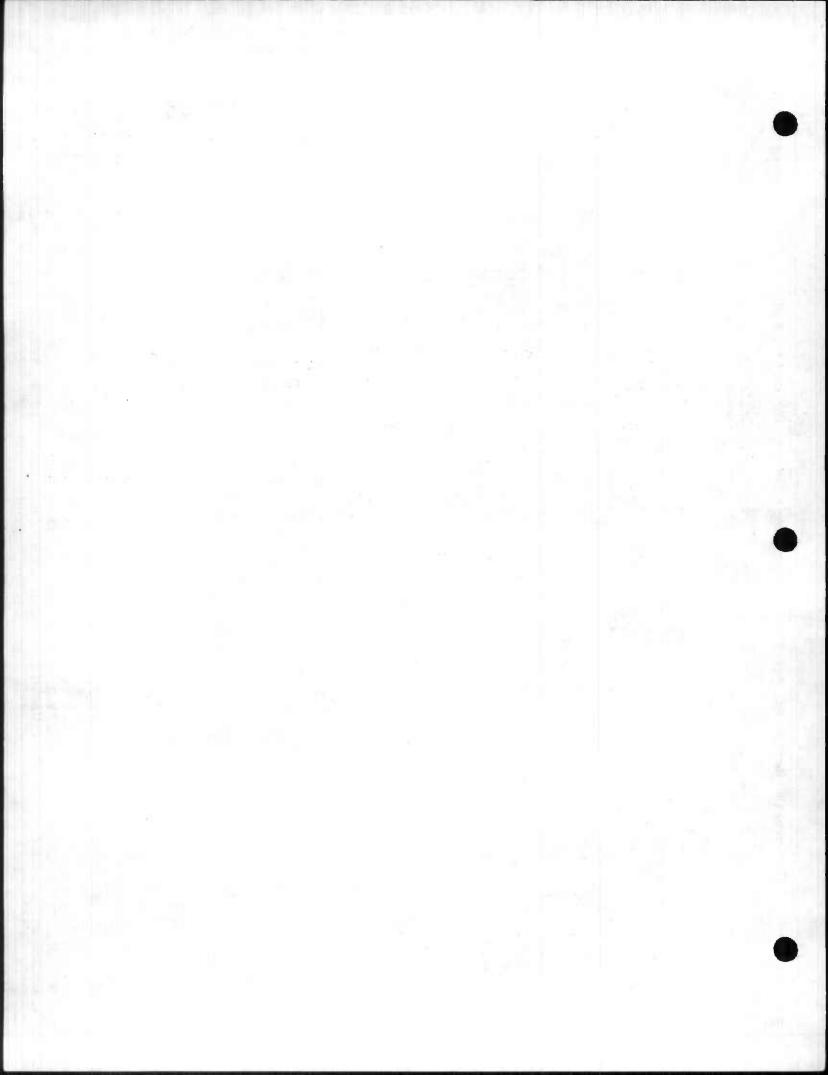
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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Deeth Month **Physician** NANNIE 601 N /Medical County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE BALTIMORE Gry MEDICAL CENTER 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex Birthpleca (Stete or Foreign Country) **Funeral** 10 M 20 F 85 March 8, 1914 Maryland Director 220-05-3080 Usual Residence of Decedent the Manyland 10b. County 10c. City. Town or Location 10a, State 10d. Inside City Limits tem 27 te marked other than "natural", or frama 23a or 23a-4 ahow other treumatic event, the Medical Examinar must be notified at Maryland Baltimore City Baltimore 1 Yas 2 No Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 2300 Elsinore Avenue 21216 U.S.A. Funeral deeth 12. Was Decedent Ever in U.S.
Armed Forces? Unknown
1 | Yes 2 | No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - American Indian. 11. Marital Status Black, White, atc. e filed within 72 hours efter al Hygiena. other than "natural", or its 1 Never Married 2 Married Specify: White Baitimore, Maryland 21215-0020 1 Yas 2 No Specify: à 3⊠ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown Unknown Unknown permit. Pages 1 end 2 should be file Department of Heelth end Mental Hy Important: if Item 27 ie marked othe eny Injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Unknown 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other pleca) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4□Donation 5 Dother (Specify)in state 21. Signature of Funeral Service Licensee Royald S. Wade <sup>22</sup> Name end Address of Fecilib Board, 655 W. Baltimore Street Director Walle Baltimore, Maryland 21201 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, or heart feiture. List only one cause on each line. Onset and Death Physician Immediete Cause (Final disease or condition resulting in death) /Medical NEW MONIA Examiner Due to (or as a consequence of) week Examiner the attending physician and hed for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DoguBirus INFE CODO ULCENS SACRUM Division of Vital Records. P 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy STATUS DOFF To the Hospital or Attanding Physician: The law within 24 bouts after death.
To the Funeral Director: Attanthis certificate has completely filled in by the funeral director, page 2 Unsevent Accions 1 Yas 2 No 1 Yas 2 No Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 2 1 Yes 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier LE Cashing Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as steled.

2 Decided Examiner On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only 29d. Data signed (Month, Dey, Year) 29b. Signature and title of contil completed cause of death (Item 23a) (Type, Print) 5 CORROT 31. Data filed (Month, Day, Year) 32 Registrar's Signature State Registrar



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1655 1999 Helen M. Hopper MAR 18 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL BALTIMORE AGNES Hours Min. SEP 10, 1915 If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Maryland 1 M 2 KF 83 Director 218-01-0406 Usuel Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. inside City Limits ahow than "natural", or items 23s or 28s-f short the Madical Examiner must be notified at MD N/A Director Baltimore 1 Yes 2 No 10e. Sireet and Number 10f. Zip Code 10g. Citizen of What Country? 3320 Benson Avenue 21227 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Merital Status Black, White, etc. filed withIn 72 hours after 1 Yes 2 No 1 Never Married 2 Merried 21215-0020 1 Yes 2 No Specify: Specify white by 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Mirkle Mairlen Sumame) Be Peges 1 and 2 should be 1 nent of Health and Mental I mt: If item 27 is marked or Gilbert Maris Emma Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .0 Marlene Dornicak - daughter 6032 Edmondson Ave., Catonsville, Md. or other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 3/22/99 1 Ø Burial 2 ☐ Cremetion 3 ☐ Removal from State Department of important: If any Injury or DDCs. Meadowridge Memorial Park 4 ☐ Donalion 5 ☐ Other (Specify) Elkridge, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licenson Gary L. Kaufman Funeral Home @ Meadowridge MP. Inc. 23a. Part1. Enter the disease, or comblications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer fellure. List only one ceuse or each line. 21075 Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel CHRONIC OBSTRUCTIVE PULMONARY DISTAGE disease or condition resulting in death) Examiner Due to (or as a consequence of): Sequentially iis! conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thel initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): signed by the attending p Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1⊠Yes 2□ No 3□ Probably 4□ Unknown UROSEPSIS Completed by Records, 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? ATPERTENSION 2 No ALZHEIMER'S DEMINICA 1 Yes 2 No certificate Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1□ Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28a. Date of injury (Month, Day Year) 28b. Time of 28c. injury at Work? 1 Netural 5 Pending investigation death. 1 □ Yes 2 □ No 2 Accident after death Director: 6 ☐ Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 24 hours a Funeral D Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and litle of certifier 0 MARCH 18th 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. FRANCIS BUADI, ST. AGNES HOSPITAL, 900 CATON AVENUE, BALTIMORE, MD 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Ray 6/95

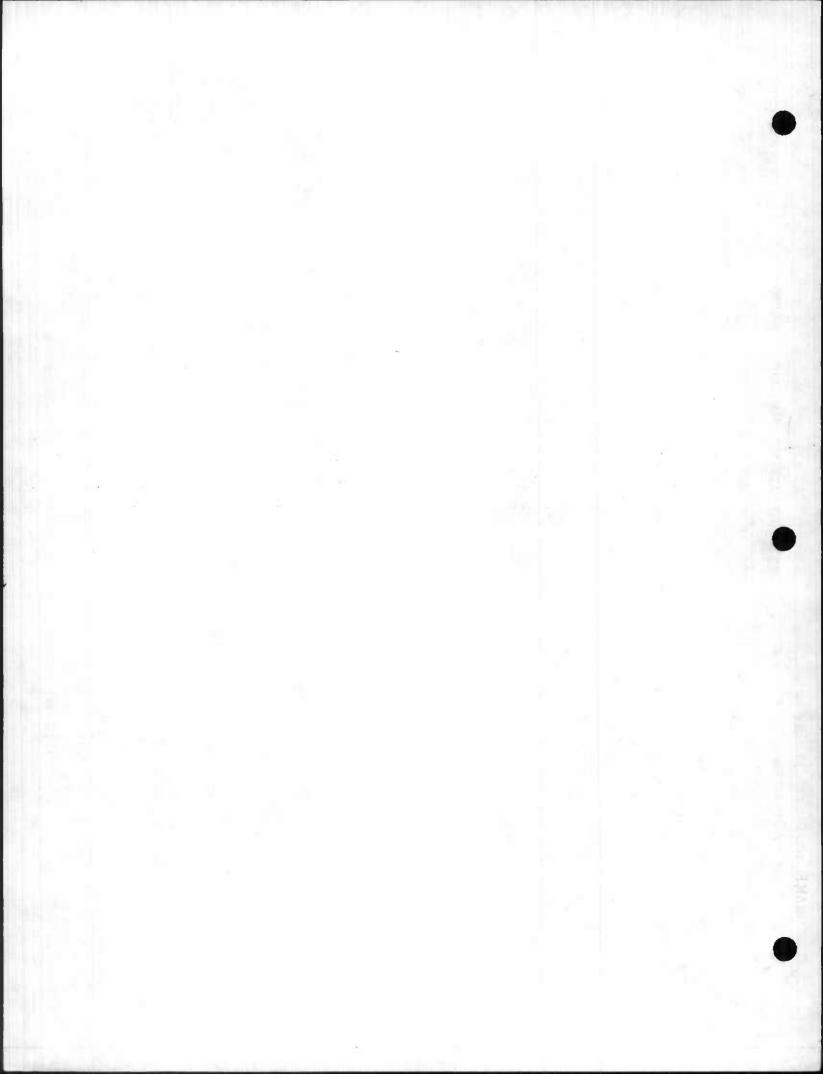
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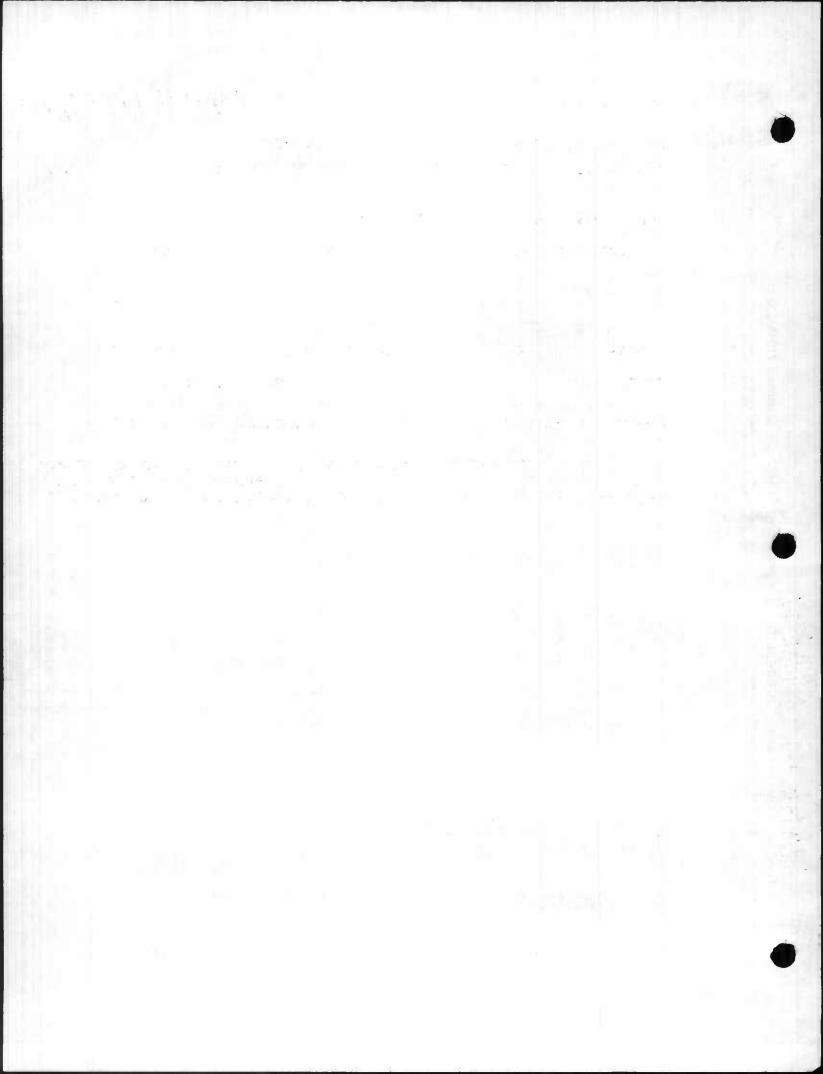
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					laryland /	-	rtment of tificate o	Health and of Death	Mental H	ygiene 9	09	401
	Physician /Medical	1. Decedent's Name (First, Middle, Last) MABEL B. HARRIS							3 Dele of C	R 98/	CHI Y	Time of Death  730:AM
	Examiner Funeral Director	LEVIND 5. Social Security					If Under 1 Ye		RE	N/	A 9. Birthplace	(State or Foreign N.C.
	pue *-	Usual Residence	of Decedent		10c. City, T	own or Loc	eation				10d. In	side City Limits
100	Menyl	MD.	BALTIMO	ORE	V	ILLA	NOVA					☐ Yes 2€ No
	ifter death with the Maintre result to rectified result to rectified Funeral Director	10e. Street end N 4014 E	umber BUCKINGHAN	1 RD.			10f. Zip Cod 2120			10g. Citizen of USA	What Country?	
020	To and 2 should be filed within 72 hours after death with the Manyland 1 tend 2 should be filed within "netural", or items 23a or 28s-f show other traumatic event, the Medical Experiment nate to notified at To Be Completed by Funeral Director	3 🗆 Widowed	rried 2/2 Married 4 Divorced	12. Was Deceden Armed Forces 1  Yes 2  If Yes, Give Yeer or Detes	? No		Vas Decedent of Yes, specify O	of Hispanic Origin? ( tuban, Mexican, Pue No Specify:	Specify Yes or had rice Rican, etc.)		ce - American Ind ck, White, etc.	dian,
15-0	72 ho	(Spi	15. Decedent's E	ducation ede completed)	1	6a. Decede	ent's Usuel Ockind of work do	cupation ne during most of we tired)	orking	16b. Kind of B	usiness/industry	
2121	led within 72 ho lygiene. ner then "neturing, the wester! Completed	Elementary/Sec	ondary (0-12)	College (1-4or	5+)		STERED			HEALT	ALTH CARE	
Baltimore, Maryland 21215-0020	2 should be filed within 72 hours Le marked cuber than "natural", raumatic event, the Medical Ex- To Be Completed by	17. Fathers Name	G (First, Middle, Last MASON	)						le, Meiden Sumen ILKI NS	ne)	Ty44
Aary	2 should we had Missing the mark		Name/Relationship		1			eet end Number or F				a)
e,	os 1 end of Health Item 27	JOSEPH 20a. Melhod of Di	HARRIS (F	HUSBAND)	20b. Place		BUCKIN sition (Name of netory or other)	IGHAM RD.	BALTIMO	7	1217 City or Town, S	State
m or		1 🗆 Burial 🔞	Cremation 3	Removal from Stete	9				3 22 00			
Balti	permit. Pages Department of Important: If it any Injury or once.	4 Donetion 5 Other (Specific NTOMBMENT DRUID RIDGE CEMETERY 3-22-99 BALTIMORE,  21. Signeture of Funeral Service Licensee 22. Name end Address of Facility PHILLIPS FUNERAL HOMING 1721-27 N. MONROE ST. BALTIMORE, MINISTER 1721-27 N. MINISTER									номе, Р	.A.
	Physician /Medical Examiner	shock, or he Immediate Cause disease or condit resulting In death	ert failure. List only (Fine) ion )	plicetions that ceuserone cause on each	erchral Due to (or es	Thr	บกร่อ รัร uence of):	ying, soon as cardin	ou in teaphic tory	011000,	Inter	roximate rval Between et and Deeth
1 ABE Box 68760,	et the death certificete be executed by the attending physicien and eteched for use es the buriel-transit Physician/Medical Examiner	Sequentielly list of any, leading to cause. Enter Und Cause (Disease of their initiated even resulting in death	ts	c	Due to (or as							
S. 6	the att	Part II. Other sign	ificant conditions	contributing to death	but not resultin	g in the un	derlying ceuse	given in Part I.	23b. Di	d tobacco use co	ontribute to the	cause of death?
S, P.	es thet the igned by be detected by Phy			13					11	Yes 2□ No	3 Probably	Unknown
S	been s should								24a. We	es an autopsy formed?	available	utopsy findings e prior to lion of ceuse o?
N IE									10	Yes 2 No	1 ☐ Yes	2 □ No
N N	ce red	25. Wes case reference examiner?	erred to medicel	Hospital:	ient 2 ER	/Outpatient	3 DOA		eath (Check onl		ner (Snecifu)	
AA A	Attending Physic deeth.  •ctor: After this by the funeral diffication: To	27. Menner of Dec	5 Pending investigation	28a. Date of in (Month, D	ury 28	b. Time of Injury	28c. I	njury at Work?	Home 5 Realdence 8 Other (Specify)  28d. Describe how Injury occurred			
Divis		3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, fectory, office bullding, etc. (Specify)  28f. Location (Street end City or Town, Stete)								own, Stete)		
<u></u>	To the Hospital or within 24 hours after to the Funeral Dir completely filled in Medical Cert	29a, Certifier (Check only one)	12 Certifying Pi 2  Medicai Exa	nysician: To the besi miner: On the basis end manners	of examination	dge, death and/or invi	occurred at the estigation, in m	e time, date end plac ny opinion, death occ	ce, end due to the curred at the tim	e cause(s) and m e, dete end place,	enner as steted. end due to the	ceuse(s)
OF .	To the Company	29b. Signature en	)					ense number		29d. Date signe	ed (Month, Dey,	Year)
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		Raymond 1	nillo 25	completed cause of		Soute	202	Reistestown	MD			
	State Registrar	31(Date filed (Mo			rer's Signeture		· So	31. Kg/				



Please Type or Print in Biack Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month Mar Jacon Hains .45pm 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Yeer Birthplace (State or Foreign Country) Months Deys 1X M 2□ F Hours 86 Yrs. 060-07-1813 SEPT.8,1912 CANADA **Usuel Residence of Decedent** 10b. County 10c. City, Town or Location 10d. inside City Limits 1 X Yes 2 ☐ No MD HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5764 STEVEN FOREST ROAD #222 21045 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1∆ Yes 2 □ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, Whita, etc. 1 Nevar Married 2 Married WHITE 1 Yes 2 No Specify: Specify 3 ☑ Widowed 4 ☐ Divorced Year or Detes: 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) CUSTOMS INSPECTOR U.S. GOVERNMENT 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) **ABRAHAM** MAX HAINS BESSIE IDA SCHATTENSTEIN 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNA LUTZ / DAUGHTER 7779 NEWINGTON WOODS DR. - SPRINGFIELD, VA 22153 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 🔀 Removel from State 3/21/99 MT. SINAI CEMETERY PORTLAND, MAINE 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signeture of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, 21208 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximeta Intervel Between Onset and Death neumonia Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of): Due to (or es a consequence of): Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Homosis 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 2 DINO 1 Yes 20 No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Thipatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

**Physician** /Medical Examiner Examiner

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should be det

After

deeth.

To the Hospital within 24 hours a To the Funeral D

completely

after deeth Director:

Physician/Medical

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Completed

Be

Medical Certification: To

requires that the death certificate be executed

P.O. Box 68760.

Records.

Division of Vital or Attending Physician:

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Item 27 Is marked oth
any Injury or other traumatic event

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funeral

by

Completed

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with the Marylend

72 hours after

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

	axaminar?	
27.	Mennerol	Death

5 Pending Investigation 6 ☐ Could not be 28e. Dete of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 □ Yes 2 □ No

29a. Certifier (Check only one)

1 Neturel

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated.

29b. Signetuse and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

cause of death (Item 23a) (Type, Print)

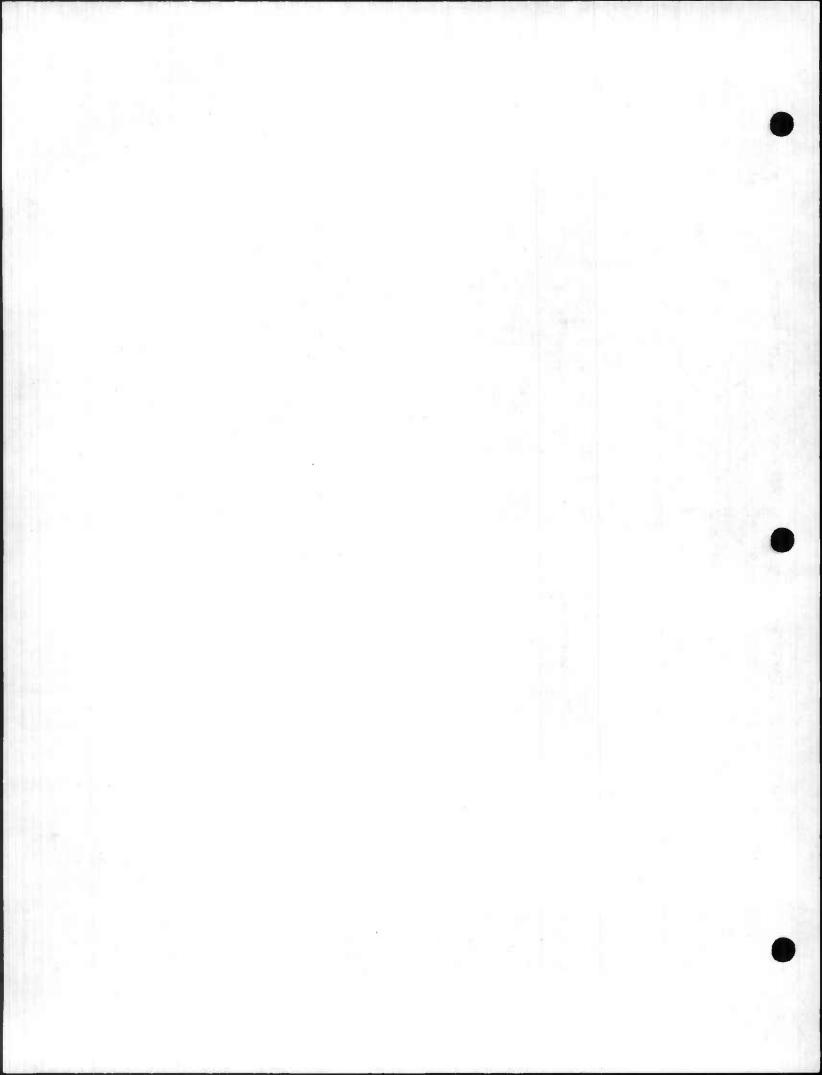
Neme and address of person who completed (a. 1- YOUNG Old Annapolis Road, Ellist City, MD 2044 9501

31. Date filed (Month, Day, Year)

1999

32. Registrar's Signeture

State Registrar



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month 3 19 Ho Imes 1999 Sherlock 6:30 a.m. 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2313 N. Dukeland Street Baltimore If Under 24 Hrs. If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Min Months Deys Hours 1⊠M 2□ F 220-03-0861 82 16 1917 Va Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md 1 ☐ Yes 2 ☐ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2313 N. Dukeland Street 21216 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 k1 Yes 2 □ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Meritat Status Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 Ø No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Chesapeake Motor Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Freight Checker N/A 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) George W. Holmes Minnie M. Glenn 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sallie Holmes-Wife 2313 N. Dukeland Street Baltimore, Md 21216 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Durial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) St Matthew Lutheran Church Cem 3-26-99 Meherrin, Va 21. Signature/of Funerel Service License 22. Neme end Address of Facility March F/H West 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Baltimore, Md 21215 Approximete Intervel Between Onset end Deeth Caucer - Stage 4 Immediate Cause (Finet disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? rostate cance 1 Yea 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? Vocal cord cancer 24a. Wes an autopsy performed? 1 Yes 1 □ Yes 2 □ No 25. Was case referred to medicat 28. Place of Deeth (Check only one) Hospital: 1 topatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home Standarde 6 Other (Specify) 1 Yes 20€No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Netural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Examiner physician and s the burial-transit The law requires that the deeth certificate be executed Box 68760, Physician/Medical 50 6 by Completed certificate Be edical Certification: To this After thi

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

tem 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filled within 72 hours effer of Department of Heelth and Mentel Hygiene. Introdumit: if flem 27 is marked other than "natural", or flem sny injury or other traumatic event, the Headen Pages.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Director:

 Hospital or Attending P n 24 hours after death.
 Funeral Director: After t To the Hosp within 24 hor To the Fune completely fi

**DHMH 16 Rev 6/95** 

State Registrar

29b. Signeture and title of certifier

4 ☐ Homicide

(Check only one)

29e. Certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

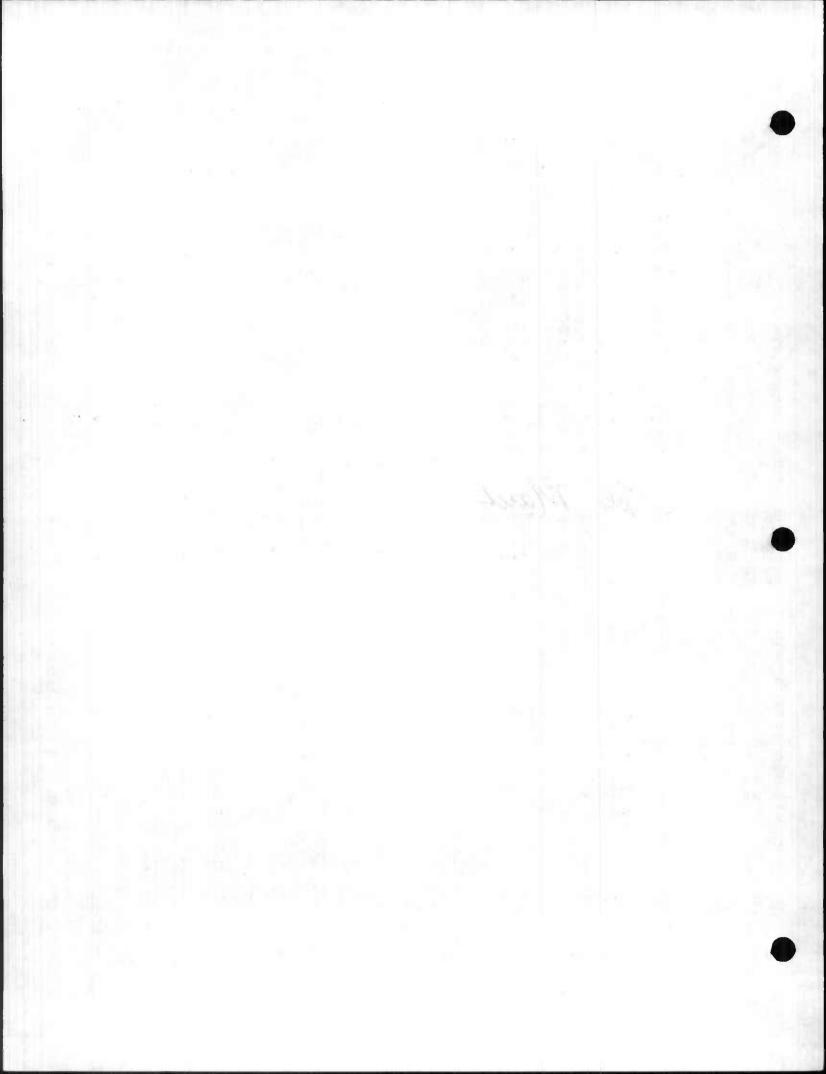
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year)

30. Neme and address of person w o completed cause of death (Item 23a) (Type, Print)

REGRO BALTIMORE

31. Dete filed (Month, Day, Year)

32. Registrer's Signature



# Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Ann **Physician** Verna Howeth 1: 40 AM March 20, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3436 Loganview Drive Dundalk Baltimore If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 212-14-8442 Yrs 84 March 13,1915 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits 1 ☐ Yes 2 ☒ No Directo 288-4 Maryland Baltimore Dundalk 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 3436 Loganview Drive 21222 United States Berrs 23a 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedant Evar in U,S. Armed Forcas? 14. Race - American Indian, 11 Maritai Status Black, White, etc. 1 ☐ Yes 2 ☐ XSo 1 Never Married 2 Married 8 If Yes, Give Year or Dates: 21215-0020 1 ☐ Yes 2X No Specify: Specify: 3 3₺ Widowed 4 Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Nursing Assistant Health Care Saltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fi tealth and Mental H m 27 is marked off Be Mox Derka Louise Lampki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. tntormant's Name/Relationship (Type, Print) Apt. C3 Bonx, NY Illam 27 Verna Zapata/Daughter 2160 Holland Ave. 10462 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ъ any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 3/23/1999 Baltimore, Maryland 21. Signature of Funge 22. Nama and Address of Facility Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tallum. List only one cause on each line. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE Examine Due to (or as a consequence ot): Examine ARTERIOSCLEROTIC HEART DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Due to (or as a consequence of) Box ( Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION signed b Records, þ 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to Completed completion of cause of death? 1 Yea 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 2 Yes 2 No this 27. Manner of Death 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Attanding 1 Natural 5 Pending invastigation 1 ☐ Yes 2 ☐ No death. 2 Accident after deat Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or To the Hospital or within 24 hours aft To the Funeral Dis completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as atated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date aigned (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. License number \$ 8. Vinera work MD. PA 13664 march 77, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21222 1576 MERRITT BLUD B. C. VENERACION IR M.D.PA.

A ME

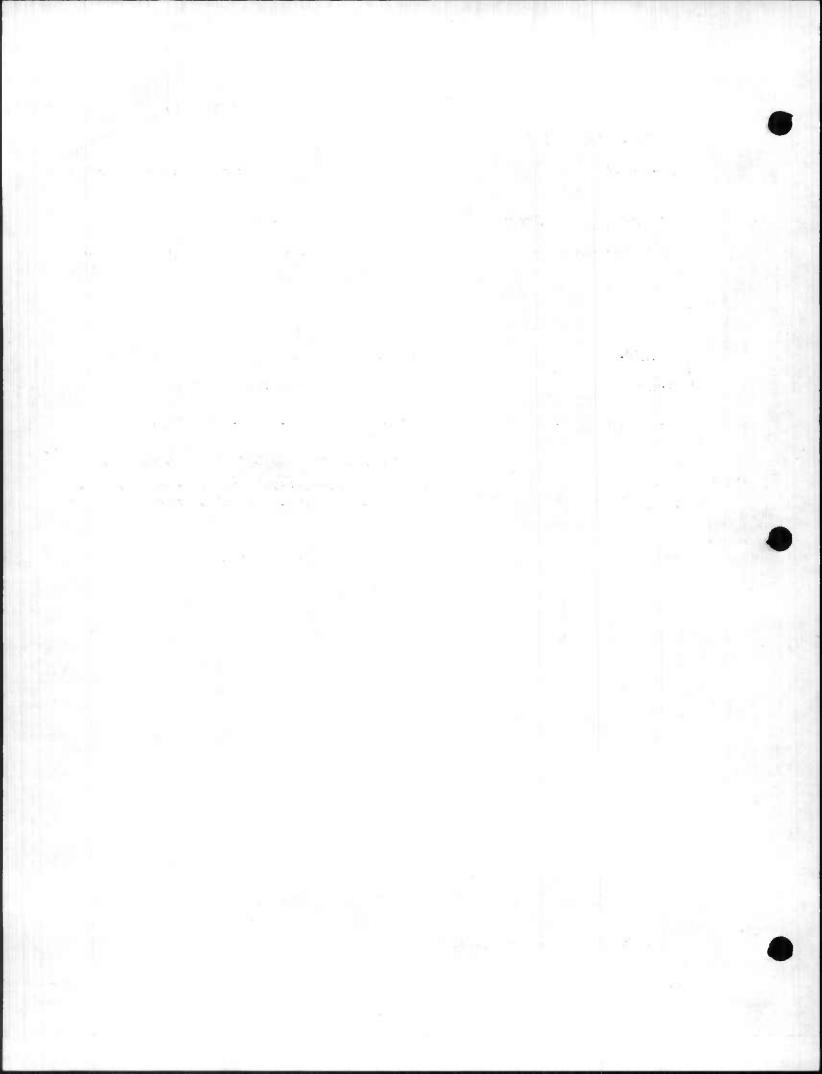
State Registrar

DHMH 16 Rev 6/95

ate 31. Date filed (Month, Day, Year) MAR 2 3 1999

32. Registrar's Signature

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day MARCH 4b. City, Town, or Location of Death 1999 RACHEL AUGUSTA CLAYTON 18 7:23 pm 4c. County of Death 4a Facility Neme (If not institution, give street and number) MANOR CARE ROSSVILLE MEDBRIDGE ROSEDALE If Under 24 Hrs. BALTIMORE If Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min 1 M 2 TF 215 03 6539 FEB 17 1914 MARYLAND Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE MIDDLE RIVER 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 13216 GUNDALE **AVENUE** 21220 USA 12. Was Decedent Ever In U.S. Armed Forces? 1 Yes 2 Xho If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) HOMEMAKER 0 OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) EDWARD E. CLAYTON ALICE E. JOINER 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD C. HOWE SR / SON 13216 GUNDALE AVE BALTIMORE, MD 12220 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 3/22/99 MORETAND MEMORIAL BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 23a. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. MD 21237 Approximete Interval Between Onset end Deeth immediate Cause (Finel disease or condition resulting in death) ehydration ression Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to for es e consequence of) Diabetes Due to (or es a consequence of) Hypertension 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Wes an eutopsy performed? completion of cause of death? 2 No 1 Yes 1 □ Yes 2 □ No 25. Wes case referred to medical exeminer? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

The law requires that the death certificete be executed attanding physicien end for use as the burial-transit Division of Vital Records, P.O. Box 68760, signed by the a certificate has b or Attending Physician: director, this funeral octor: / by the f n 24 hours efter der he Funeral Director pletely filled in by th

Physician/Medical þ Completed Be Certification: To edicai

**Physician** 

/Medical

Examiner

Directo

Funeral

by

Completed

**Funeral** 

Director

permit. Pagas 1 and 2 should be filed within 72 hours aftar deeth with the Merylend Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic event, if a Modical Examination on the profiled at once.

**Physician** 

/Medical

Examiner

Examiner

altimore, Maryland 21215-0020

To the To the To the

State Registrar

6 Could not be determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner stated. 29d. Dete signed (Month, Dey, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

45568

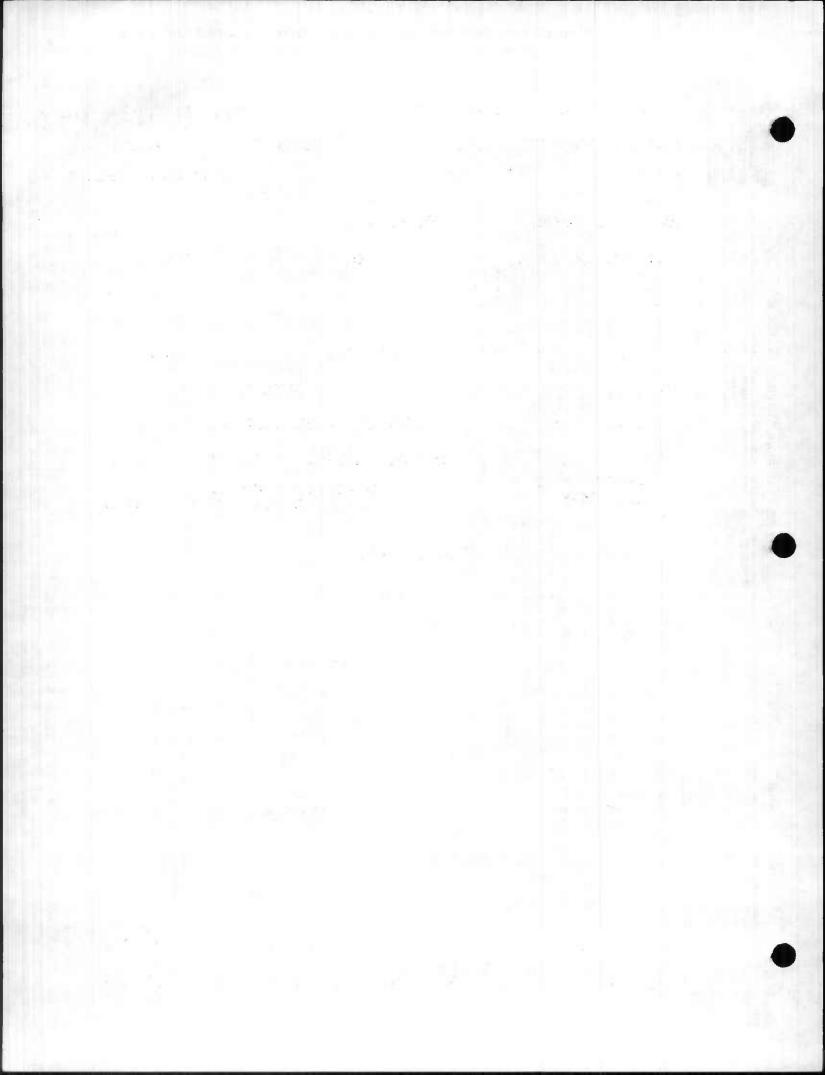
cause of deeth (Item 23e) (Type, Print) 30. Name end eddress of person who con Srad ford m.D 31. Date filed (Month, Dey, Yeer)

MAR 23 1999



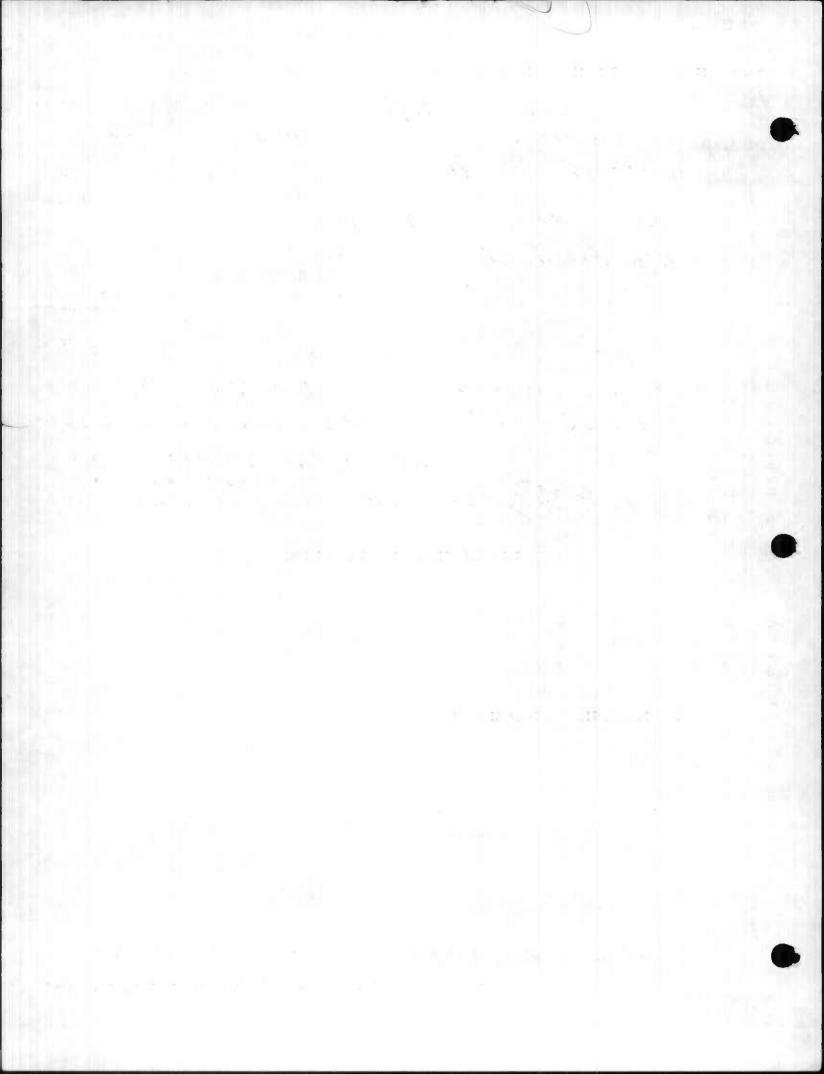
**DHMH 16 Rev 6/95** 

To the Fune



### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

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		1. Decedant's Name (First, Middla, Las			,					2. Date of Deat	h	Van	3. Tima of Death	
Physicia		JOANNE HOPKINS							MARCH	Day 19, 199	Year 9	7:56P.M.		
/Medica Examine		4a Facility Nama (If not institution, give street and number)  4b. City, Town, or							wn, or Lo	cation of Death	4c. County	of Death		
		CHURCH HOME HOSPITAL BALTIMO							CIMOF	RE .		NA		
Funeral		Social Sacurify Number     6. S		. Age (In yrs. las	t birthday)	If Undar Months	1 Yaar Days	If Under Hours	24 Hrs. Min,	8. Date of Birth (Month, Day,	Year)	9. Birth	plece (State or Foreign	
Director		216-74-2433	□ M 2 1 F	41	Yrs.	Williams	Duyo	110010	10101.	2-28	-58		MD	
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		30. Name and address of person who	^	1			Des	CI		D-74.		1	21201	
CALL		Stephen 5, 31. Date filed (Month, Day, Year)		gistrar's Signatur		/111	renn	Stre	et,	Baltimo	re, Mai	уутаг	M 21201	
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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:33P.M Maurice Edgar Isennock Jr. varch 30 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore Center Square Klin Hospital osedal 1 If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 N 2 □ F Months Days 218-18-1835 78 September 18,1920 Baltimore Co., Md. Director Usual Rasidence of Decedent deeth with the Marylend 10b. Counts 10d. Inside City Limits 10a State 10c. City. Town or Location d 2 should be filed within 72 hours efter deeth with the Manylen than d Mentel bytjene. 7 is marked other than "netural", or items 23a or 28a-f show traumatic event, the Medical Examples from the notified as 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? -sennock, Maurice 9210 Cowenton Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? Black, Whita, atc. 1 XYes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2XXMarried Specify: White 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collage (1-4or 5+) Operating Engineer C.J. Langenfelder Co. 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Peges 1 and 2 should be I nent of Heelth and Mentel I Maurice E. Isennock Sr. May E. Jones 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Heelth in Important: If them 27 is any injury or other tra Amelia Isennock (Wife) 9210 Cowenton Avenue Baltimore, Maryland 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery March 24, 1999 Baltimore, Maryland 21. Sjegsture of Funeral Ser 22. Name and Address of Facility Lassahn Funeral Home, Inc. 23e. Pert1. Enter the disease, or complications that caused hadeath. Do not enter the mode of dylng, such as cerdiac or respiretory arrest, shock, or haart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final 28 Minutes disease or condition resulting In death) Examiner Examiner physicien end s the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata ceusa. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): attending I Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributa to the causa of deeth? n signed by the Mellitis 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peen tension il director, page 2 s 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Be 25. Wes cese referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death. To the Funeral Director: After this scompletely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Panding Invastigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 8 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida 15 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifian Medicai (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) A4(3)

Franklin Square

Drive Baltimore,

Registrar **DHMH 16 Rev 6/95** 

State

30. Nama end address of person who completed ceusa of daath (Item 23a) (Type, Print)

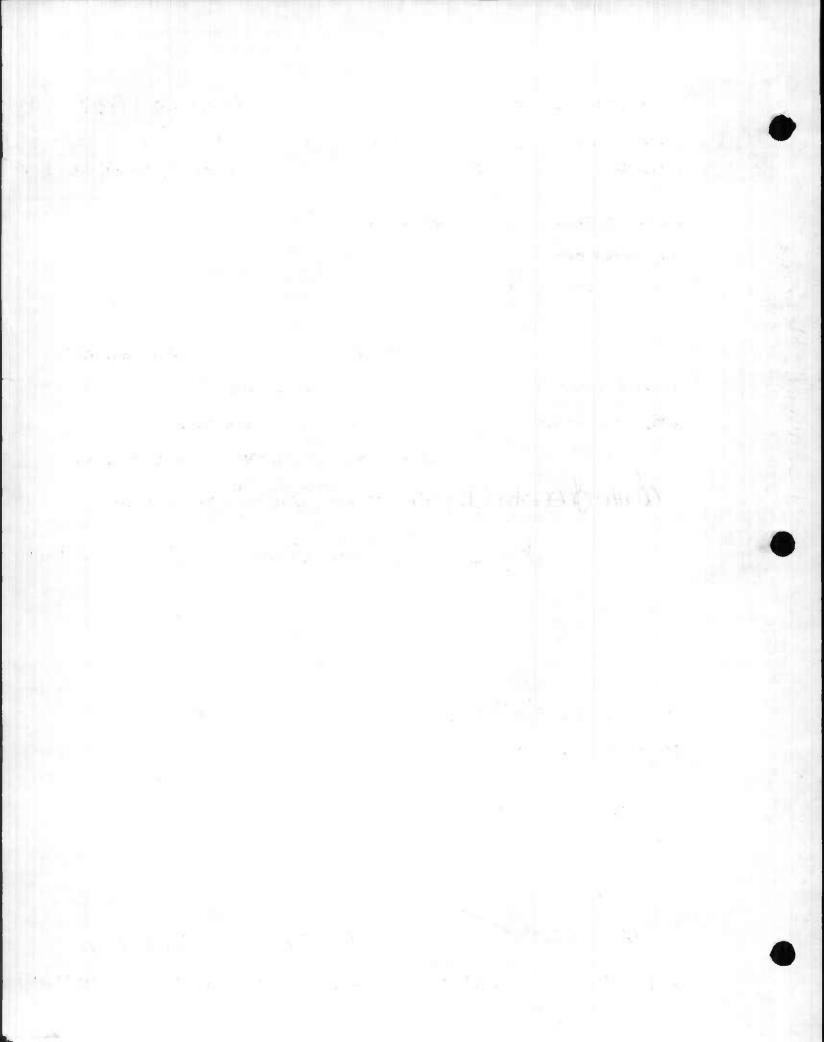
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MAR 2 3 1999

31. Date filed (Month, Day, Year)

9000

32. Registrar's Signature



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Month Russell 14, S. James March 1999 7:00 PM 4e. Fecility Name (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 105 Kennard Avenue Edgewood Harford 5. Sociel Security Number 6. Sex 1/∆ M 2 ☐ F 9. Birthpleca (State or Foreign Country) Mary Land 7. Age (In yrs. lest birthdey) 88 Yrs. 212-32-4239 Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 105 Kennard Avenue 21040 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - Amarican Indian, Black, White, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Spacify only highest grede completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Eiementery/Secondery (0-12) College (1-4or 5+) Self Owner Coal Industry 11th Grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Gilbert James Agnes Yetton 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5818 Lytle Rd., White Marsh. MD Dorothy Jean Bailey (dghtr) 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 DBurial 2 Cremetion 3 Removel from Stete Moreland Memorial Park 3/18/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Funeral Service License 22. Name end Address of Fecility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD A 476 21236 23a. Pert1. Enter the disaase, or complications that caused the deeth. Do not anter the mode of dying, such es cardiec or raspiratory arrast, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disaase or condition resulting in deeth) Sequentielly list conditions, if eny, leading to immediate causa. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Dua to (or as e consequance of). Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings aveilabla prior to completion of cause of deeth? 24e. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

2

**Funeral** 

Director

tem 27 is marked other than "natural", or fems 23s or 28s-4 show other traumatic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or ther any injury or other traumetic axen?

Baltimore, Maryland 21215-0020

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deeth

Examiner

Physician/Medical

by

Completed

Be

2

Certification:

Medical

1 Naturel

2 Accident

4 - Homicide

29b. Signeture end title of c

3 Suicide

29a. Certifier

5 Pending investigation

6 Could not be determined

funerel

in by

within 24 hours e To the Funeral C Hospital

siclan end buriel-trensit physiclan e atten ete has been signed by pege 2 should be detect certificete has or Attending Physicien: efter death. Director: After this certifice

Division of Vital Records, P.O. Box 68760.

State Registrar

31. Dete filed (Month, Dey, Year) 23

32. Registrar's Signature

30. Name end eddress of person who completed cause of deeth (Item 23e) Type, Print)

28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28d. Describe how injury occurred

1 Yes 2 No

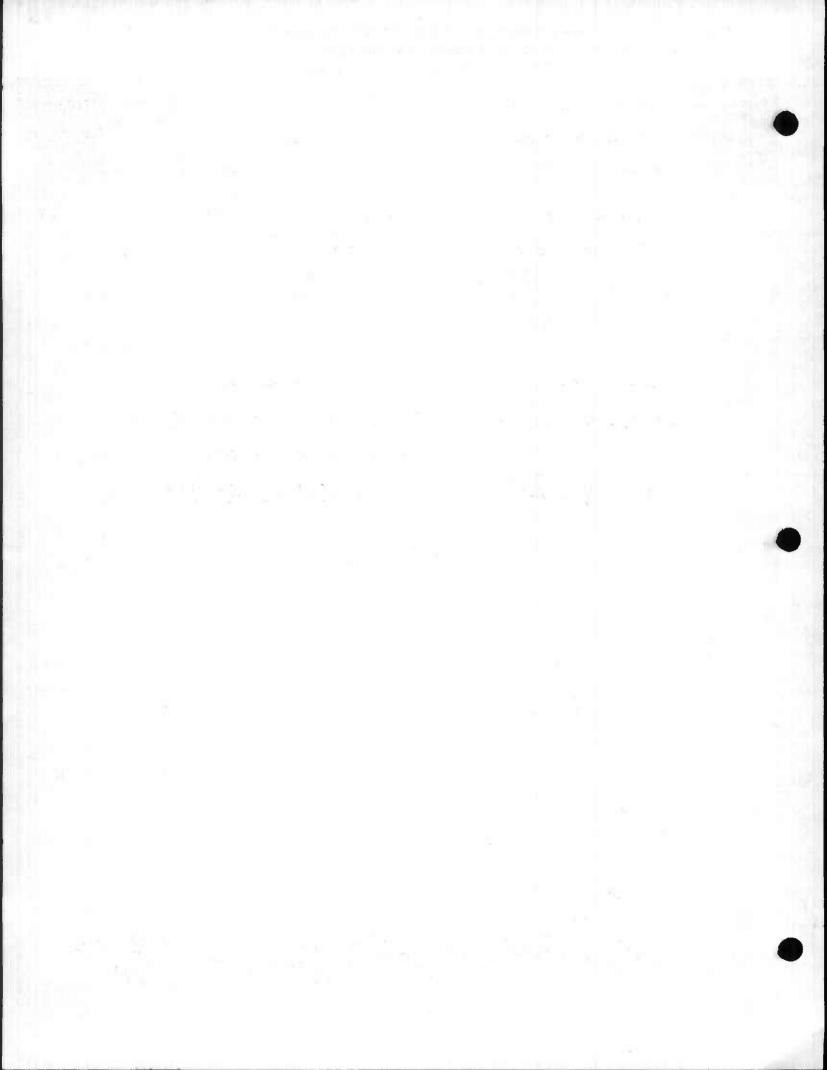
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month. Day, Year)

DO 7427 AVEC M.D. VE Square Drive CLAYTON L. MORAVEC M.D. ... GIBI FRANKLIN SQUARE DEIN CALTIMORE, MO. 2137



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH **Physician** FLORENCE LUCILLE JOHNSON 6:45 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EDENWALD RETIREMENT COMMUNITY BALTIMORE OWSON If Under 24 Hrs Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 DE 213-44-9476 Director NORTH Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MARYLAND BALTIMORE OWSON 1 ☐ Yes A No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 SOUTHERLY RD. U.S.A. 21286 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) a filed within 72 hours after deal Hygiene. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes XX No Specify: Completed by A Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filled w. Department of Heelth and Mental Hygiens important: If item 27 is marked other tha any Injury or other traumatin every than 2006s. 5+ HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHARLES WAECHTER INEZ WICKHAM 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE JOHNSON SON 428WHITE COLUMNS WAY WILMINGTON, NORTH CAROLINA 2841 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial A Cremation 3 ☐ Removal from State 3/22/99 4 ☐ Donation 5 ☐ Other (Specify) GREENMOUNT CREMATORY BALTIMORE, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MITCHELL-WIEDEFELD HOME INC. ober 6500 YORK RD. BALTO. MD. S 23a. Part1. Enter the disease, or complications that shock, or heart feilure. List only one cause on the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Intervet Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner sician and buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as physician s the buriel Physician/Medical Due to (or as a consequence of) USB ed by the a 23h. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 10 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation Natural 2 Accident 1 Yes 2 No Director 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral Dicompletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Tilner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatury and title of certifie 29c. License number DZ9769 30. Name and addr ath (item 25a) (Type, Print)

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State Registrar

**DHMH 16 Ray 6/95** 

The lew requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

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after death.

the Meryland

death

Baitimore, Maryland 21215-0020

MAR 2 3 1999

1/20 N. Rolling

31. Date filed (Month, Day, Year)

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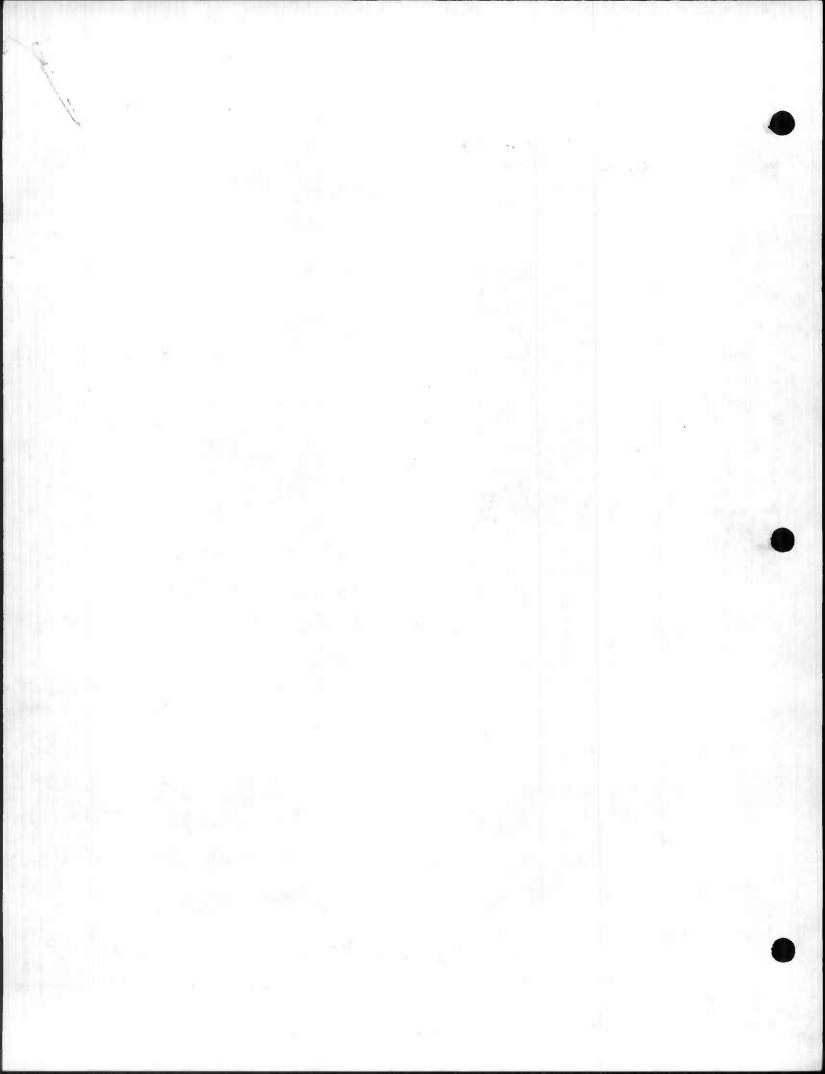


Baltimore

MO

21228

Hoverne



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month :32 PM 17, 1999 CLIFTONS JANNEY. .H. MARCH 4e Facility Nema (If not institution, giva street and number) 4b, City, Town, or Location of Deeth 4c. County of Deeth HOSPITAL MERCEY BACTIMORE If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Sacurity Number If Under 1 Year 6 Sax 7. Aga (In vrs. lest birthday) Birthplece (State or Foreign Country) 10M 20 F Days Months 5 Yrs. June 23,1941 220-36-091 MD Usuel Residence of Deceden 10a. Stete 10b County 10c. City. Town or Location 10d Inside City Limits PERRY aM BALTIMORE 1 Yes 2 No HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4018 KLAUSMIER 21736 U.SA 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No Raca - American Indien, Bleck, White, atc. 11. Meritel Status 1 Navar Marriad 2 Married 1□ Yas 2 No Specify: Specify: WhITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coltege (1-4or 5+) SUN PAPER 1.9+4 PRINTER YR. 17. Fether's Neme (First Middle Last) 18. Mother's Neme (First Middle, Meiden Surneme) JANNEY. CARRIE CLIFTON M. MARTIN SR 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) KLAUSMIER-RD CAROLYN JANNEY wife BALTO. MD 31736 4018 20b. Placa of Disposition (Name of cemetery, cremetory or othar place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 ■ Buriel 2 □ Cremetion 3 □ Removel from State 3/20/99 4 ☐ Donetion 5 ☐ Other (Specify) BALTO MD cemetery DAKLAWN 21. Signetare of Funerel Servica Licansee 22. Name end Address of Facility HARTLEY Miller Funeral Home CHTD. Willer -RD. BALTO. Harford 21234 MD 7527 23a. Part1. Enter tha disease shock, or heert feilure. or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory arrest, List only one ceuse on each line. Approximate Intervei Between Onset and Death Immediate Ceuse (Finat MyoCARDIAL INFARCTION disaesa or condition resulting in death) Hypertens Ion Due to (or es e consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events rasulting in deeth) Last Dua to (or es a consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uee contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy 1 TYes 2 No 1 Yes 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 2 SER/Outpatient 3 DOA 28a. Dete of tnjury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation Naturel 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated.

Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end placa, end due to the cause(s) and manner stated.

29c. License number

Examiner physician end s the burial-transit certificate be exec Records, P.O. Box 68760, 98 USB for ed by the e peen certificate Division of Vital director, funerel

signed b page 2 Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certifice 24 hours To the Hosp within 24 hou To the Fune completely fi

**Physician** 

/Medical

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Director

Funeral

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Examiner

Physician/Medical

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Certification:

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29e. Certifier

(Check only one)

29b. Signature end ##

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Manical Examinar must be notified at

6 permit. Pege Department of Important: If any Injury or

**Physician** /Medical

Peges 1 and 2 should be filed within 72 hours effer on ant of Health and Mentel Hygiene. Int: If Item 27 is marked other than "natural", or ite

altimore, Maryland 21215-0020

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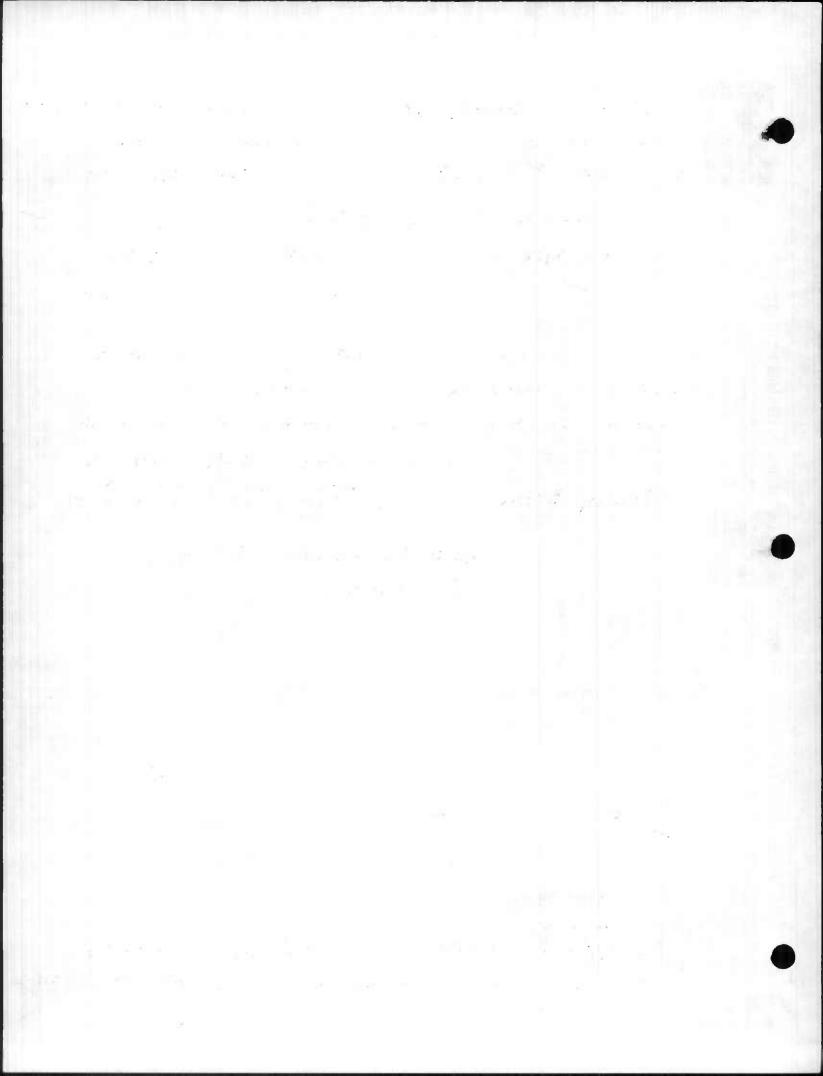
State Registrar

completed ceuse of deeth (Item 23e) (Type, Print) MERCEN HOPITAL 301 ST. PAULS, BALTO, My 21202 oBRANO, MD MAR 2 3 1999 31. Data filed /Month

32 Registrer's Signeture

0053661

29d. Data signed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death +: 50 am LARLES 1999 MARCH 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Baltimore N/A Good Samaritan Hospital If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year 5. Social Sacurity Number 6 Say 7. Aga (In yrs. last birthday) Birthpiace (State or Foreign Country) 10 M 20 F Months Days 579-09-8976 Yrs. 78 APR 10, 1920 West Virginia Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 ☐ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6116 Belair Road 21206 USA 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Biack, White, etc. 1 Pyes 2 WW II If Yes, Giva WW II Year or Datas: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Painter Housing 18. Mother's Name (First, Middle, Maidan Sumame) 17. Father's Name (First, Middle, Last) Charles Kline UNK. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ronald A. Kline/son 400 St. Mary's Rd. Pylesville, MD 21132 ce of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition

1 Burial 2 Cramation 3 Removal from Stata 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 3/22/99 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funarai Service License 22. Name and Address of Facility Cremation Society of Maryland, Dawn F. McDonald Cremation Society of Ma 299 Frederick Rd. Baltis 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one cause on each lina. Frederick Rd. Baltimore, MD Approximata interval Batwean Onset and Death Immadiate Cause (Final neumonia disaasa or condition resulting in death) Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events rasulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Miknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 DNG 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Watural 1 Yas 2 No 2 Accident 6 Could not ba 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and placa, and due to tha cause(s) and manner as stated. 29a. Certifier 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

**Examiner** attending physician and for usa as the burial-transit that the death certificate be executed Box 68760. ed by the a 4 signed t Division of Vital Records, requires peed The law certificata has or Attending Physician: director, this funeral After To the Hospital or Australia within 24 hours after death.

To the Funeral Director: After a superior of the funeral bit of the further and the

**Physician** 

/Medical

Examiner

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Funeral

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**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f ahow Insumatic event, the Medical Examiner must be notified at

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If tem 27 is marked othe any Injury or other traumatic event, pages.

**Physician** /Medical

Examiner

Physician/Medical

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Completed

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Certification: To

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30. Nama and addrass of person

31. Data filed (Month, Day, Year)

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1999

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Baltimore, Maryland 21215-0020

State Registrar

DHMH 16 Rsv 6/95

29b. Signature and title of certifier

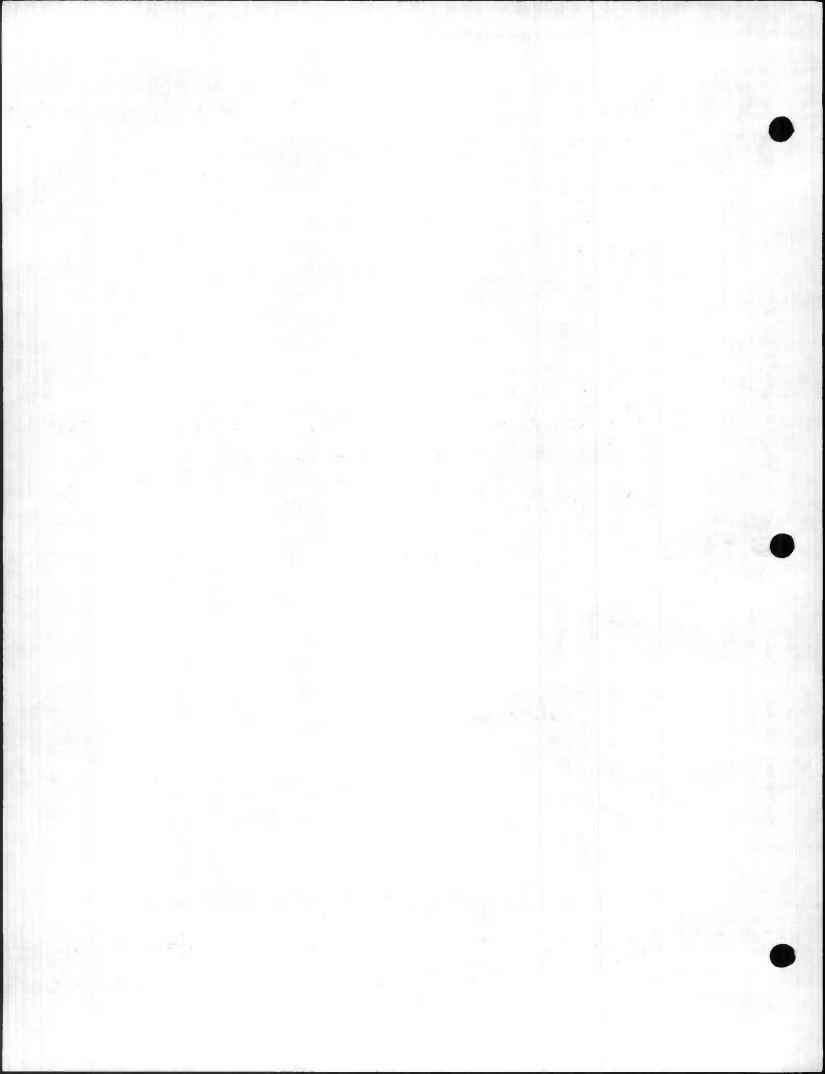
32. Registrar's Signatura

ted causa of death (Itam 23a) (Type, Print)

Zoch

29d. Date signed (Month, Day, Year) 29c. Licansa numbe

, Baltimore MO



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Kurek Catherine MARCH 17 1999 16:23 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours 1□ M 2⊠ F Months 219-16-8750 73 Oct. 8,1925 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore City Maryland N/A P Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 United States 3242 O'Donnell Street 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2€No Specify: 3 Widowed 4 Divorced White 18a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilhelmina Altwater William Mullaney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3242 O'Donnell Street Baltimore, Maryland 21224 Mr. Daniel W. Kurek/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Stanislaus Cemetery 3/20/99 Baltimore, MD 4 ☐ Donation—5 ☐ Other (Specify) 21. Signature of Fungral Service Licen 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each lip Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) hows Myocardial infarction Intra coroner Thromboembolism Sequantially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequance of): fibrillation Due to (or es e consequence of): Coronar disease artery Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 1 188 2 No 3 Probably 4 Unknown obstriction 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yas 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examine

Box 68760,

P.O.

Records.

Division of Vital or Attending Physician:

death.

24 hours after deat Funeral Director:

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**Physician** 

/Medical

**Examiner** 

Director

Funeral

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**Funeral** 

Director

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death

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Hem 27 is marked other than "natural" — honce.

Examiner Physician/Medicai þ Completed Be Medical Certification: To

25. Was case raterred to medical examiner?
1 ☑ Yas 2 ☐ No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 1 E Natural 5 Panding Investigation 1 ☐ Yas 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

6 Could not be datarmined 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 Homicide

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of court 29c. License number 29d. Date signed (Month, Day, Year) D36161 MO

Tene

30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)
Peter Schuyler Greene, MD Balach Johns Hopking Hosp. Balkhare MD Schuyles 618 Peter 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

29a. Cartifian

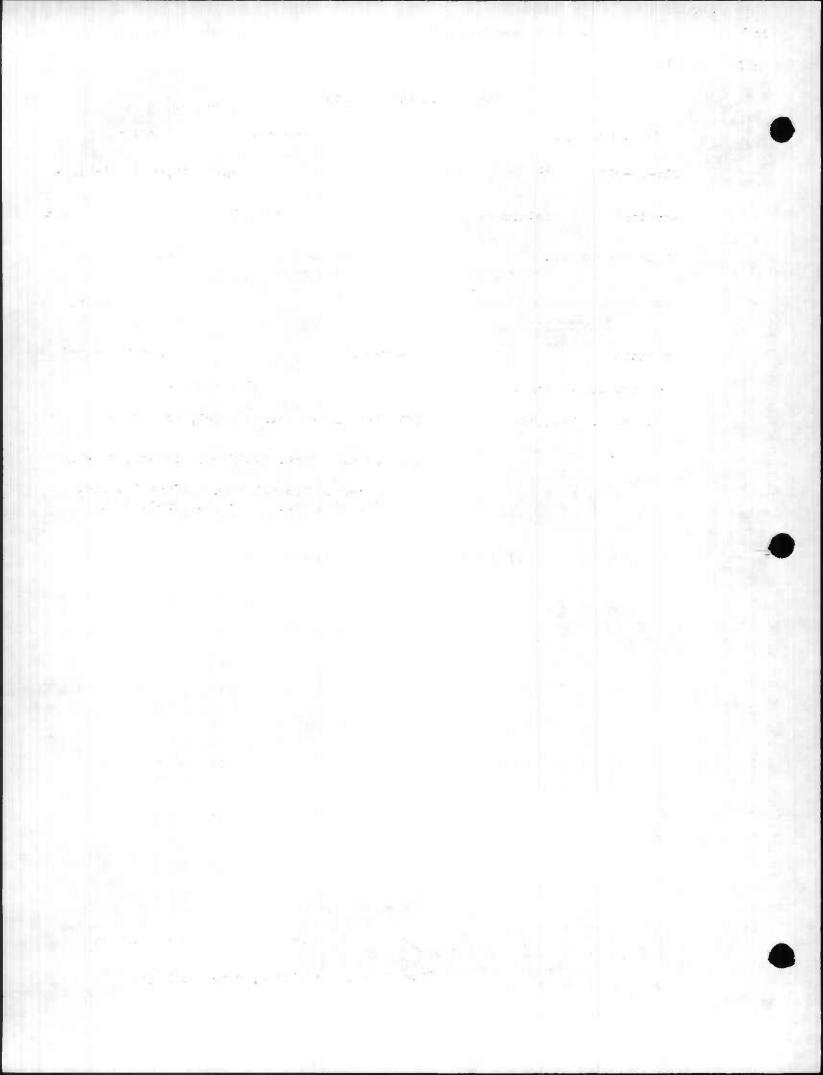
MAR 23 1999



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State	of Maryland	/ Department	of He	ealth and	<b>Me</b> ntal	Hygiene
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THOMAS (		KNUPT	Otate of Mil	aryland /	Certific		Death		Reg. No. 9 9	0	9413	
Physicis		1. Decedent's Name (First, Middle, L	Thomas	Cur		Knupp		2. Dete of De Month MARCH	eth Day	Year	3. Time of Death 1026 AM	
Examin		4a Facility Name (If not institution, gi 7624 CARSON AVEN					4b. City, Town, or DUNDAL	Location of Death	4c. County		E	
nore, Maryland 21215-0020 ges 1 and 2 should be filed within 72 hours after death with the Maryland and Mental Hygiena. If them 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examinat must be nothed as a lost of the contract of the medical event.			Sex 1√2 M 2□ F	e (In yrs. last bi	Yrs. If Ur Mont	nder 1 Year ths Days	If Under 24 Hrs Hours Min.	(Month. De	<sup>h</sup> , Yeer) 22,1936	9. Birthpl Count V11	lace (State or Foreign try) Cginia	
	tor	10a. State 10b. County	Baltimore	10c. City, Tow	n or Location		Dund	la1k		10	0d. Inside City Limits 1 ☐ Yes ※ No	
	Funeral Director	10e. Street and Number 7624 Carson Ave	•		101.	Zip Code	21224		10g. Citizen of V United			
15-0020 72 hours after dea "neturel", or items		11. Maritel Status  1 Never Married 2 Merried  3 XWidowed 4 Divorced	12. Was Decedent Armed Forces?  1 Yes 2 1  If Yes, Give Year or Dates:				Hispenic Origin? (Sean, Mexicen, Puer Specify:	Specify Yes or No to Rican, etc.)	Specify	e - America k, White, e		
5-0	ted	15. Decedent's E (Specify only highest gi	Education	168	. Decedent's U	Jsual Occup	petion during most of wa	dring	16b. Kind of Bu	siness/Ind	lustry	
21215-0020 d within 72 hours at giena. or than "natural", or fr Medical Exam	Completed by	Elementary/Secondary (0-12) 8 Years	College (1-4or 5	0+)	Carpen	Decedent's Usual Occupation (developed to the kind of work done during most of work life. DO NOT use retired)			Cons	struct	cuction	
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land be lental ked of k	To B	George Casper	Knupp				(	Sladys Ha	ayden			
Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic avent		19a. Informent's Name/Relationship	(Type, Print)				end Number or R				Code)	
e, Me 1 and 2 and		Dennis E. Knup	p/Son	1	38 Els	ia Dr	ive From	nt Royal	, VA 22	2630		
Pa Partition of the Par		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donetlon 5 Other (Spec	□Removal from State		of Disposition ( ory, cremetory top Se:		Corp. 3	Date /23/1999	20c. Location -			
Baltingemit. Par Department Important: any Injury once.		21. Signature of Funerel Service Lice	11×12		22. Name Dud	[Dunda]	alk, Inc. and 21222					
Physician / // // // // // // // // // // // //	ner	23a. Part1. Inter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Ather		tic	Care					Approximete Interval Between Onset end Death	
Box 68760, eath certificate be executed attending physician and for usa as the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a	·							
O. B. It death	Physician/N	Part II. Other significant conditions	ven in Part I.	on in Part I. 23b. Did tobecco use contribute to the cau								
that tha	by Phy					10	1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknow					
Records, P.O. Box he law requires that the death cer a has been signed by the attendings 2 should be detached for usa	Completed b							perfo	an autopsy med?	eva	ere autopsy findings allable prior to mpletion of cause death?	
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Division of To the Hospital or Attending Physical At hours after death. To the Funeral Director: After this completely filled in by the funeral directors.		27. Manner of Death  1 A Natural  2 Accident  5 □ Pending investigation	on	28a. Date of Injury (Month, Dey Yeer) 28b.			nyat vrk? ]Yes 2□No	28d. Describe how Injury occurred				
Divis	Certification:	3 ☐ Suicide 6 ☐ Could not lead to determined	t be ed 28e. Ptece of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (S City or Tox		er or Rure	I Route Number,	
Division To the Hospital or Attending within 24 hours after describes. To the Funeral Director: After completely filled in by the fune	edicai	29a. Certifier (Check only one)	hysician: To the best of miner: On the basis of and manner sta	exemination ar	e, deeth occur nd/or investige	red et the ti	me, dete end plec opinion, deeth occ	e, end due to the urred at the time,	cause(s) and ma dete and place,	anner as st and due to	ated. the ceuse(s)	
To the To the Common	Σ	29b. Signature and title of certifier  August	A VI	noi	(Z,Mb)		.M.E.		29d. Date signe MARCH 2	20, 19		
		30. Name and address of person who Stephen S.	Radent.	eath (Item 23er) III Pen	(Type, Print) In Stre	et, B	altimore	Maryla	nd 21201			
Sta		31. Dete filed (Month, Dey, Year)		ar's Signature	,	,						
Registra	ar	MAR 2.31	999	wa	B.	COPCO	1					



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 10:50 Am MORTON SIDNEY KAMINETZ MARCH 4c. County of Death 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death BALTIMDRE NPRTHWEST RANDALLSTOWN HRIPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Defenth, 247. 14927 6. Sex XXM 2□ F 5. Sociel Security Number 9. Birthplace (State or Foreign WASH - DC -7. Age (In yrs. last birthday) 71 yrs Months 216-22-4574 Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location MD BALTIMORE RANDALLSTOWN Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3505 STONEYBROOK ROAD 21133 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Yeer or Detes: 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married Specify.WHITE 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWNER APPLIANCE REPAIR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) **JACOB** KAMINETSKY KATIE WEINSTEIN 19a. informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AMEILA KAMINETZ / WIFE 3505 STONEYBROOK ROAD RANDALLSTOWN, MD. 21133 20e. Method of Disposition 20b. Pleca of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State WOSES MONTEF TORE WOODMOOR 3/19/99 BALTIMORE 4 Donation, 5 Other (Specify) HEBREW CONGREGATION CEMETERY 22. Name end Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 plication that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, any pluse on each line. Part1. Enter the diseaso, or conshock, or heert failure. List and Approximete interval Betw Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) a. ACVSE MYD CARDIAL INFARCTION Due to (or es a consequence of): ARTERIOSCLEDOSIL CARDIOVASCULAR DISTAST Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): Due to (or es a consequence of): 23h. Did tohecco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💥 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2K No 25 ER/Outpatient 3 DOA 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Neturel 5 ☐ Panding 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed physicien sthe burial Box 68760 P.O. Records, Division of Vital this After

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Physician

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Director

Funeral

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the Maryland

filed within 72 hours efter

Baltimore, Maryland 21215-0020

or Attanding Physician: 24 hours after death.

Funeral Director: A Hospital within 2 To the

State Registrar DHMH 16 Rev 6/95

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and mariner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number A Forth, mo

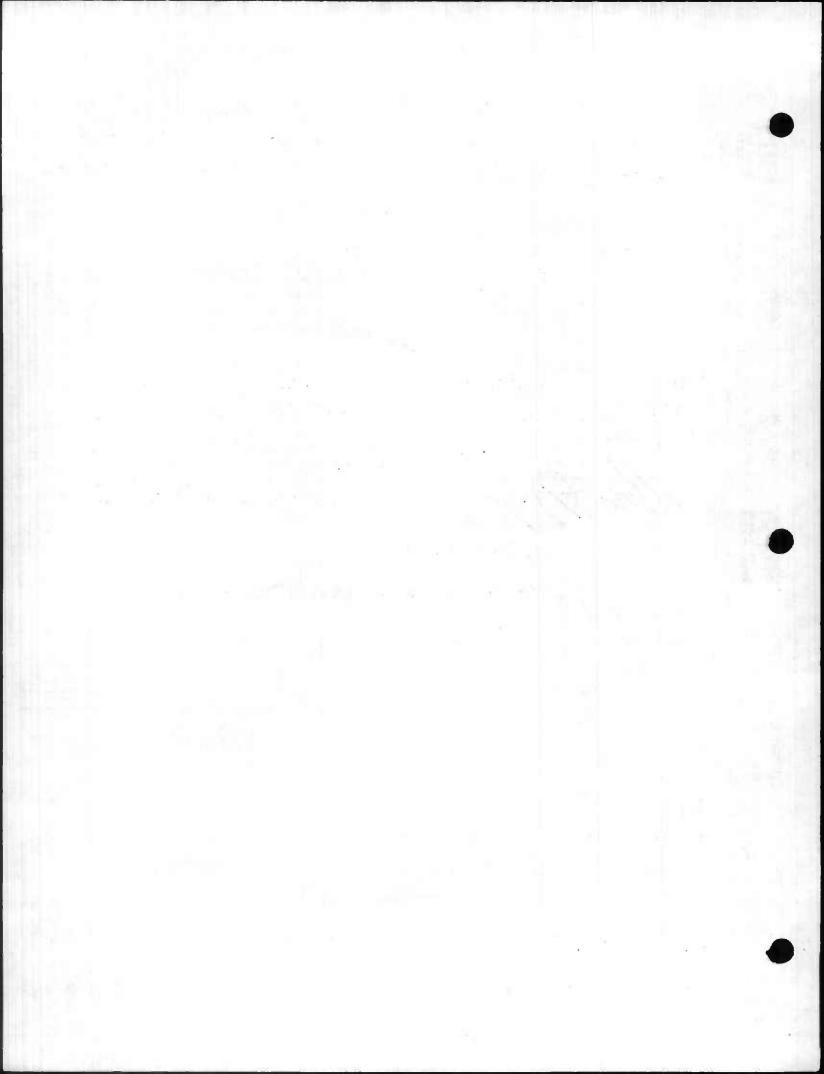
28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)

5401 CLIFFORD FABER, MO 020

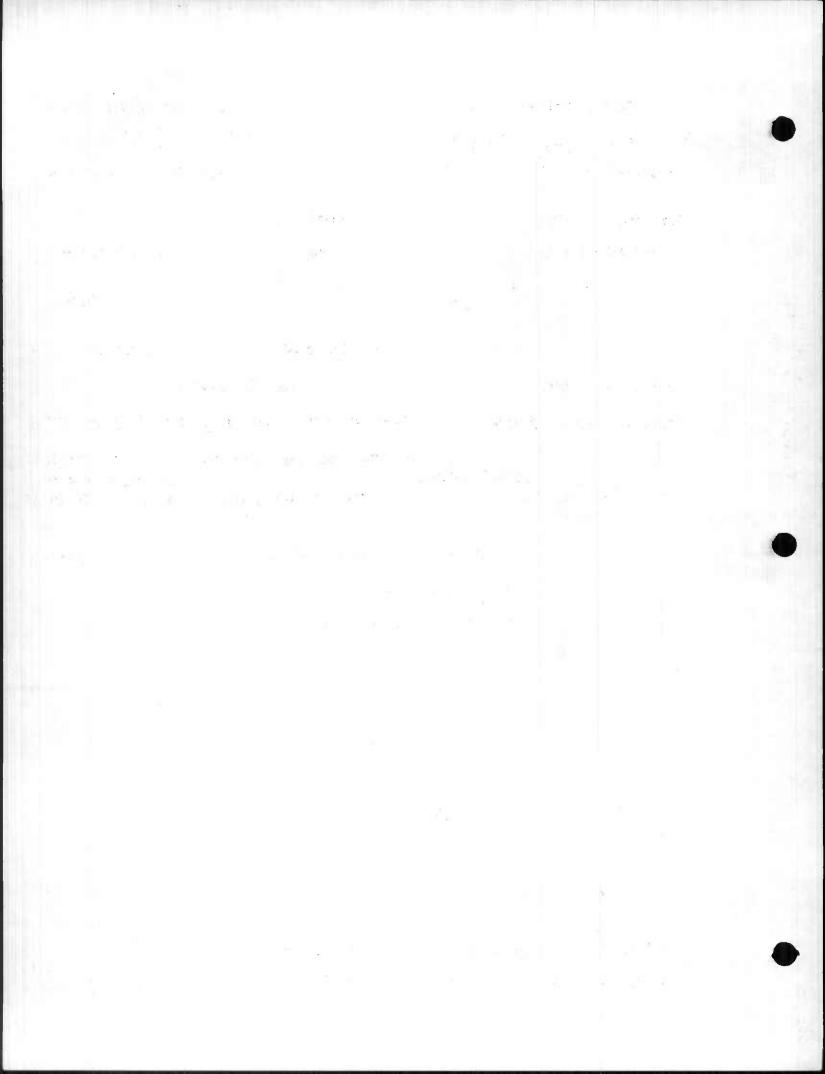
COUNT ROAD, RANDALLSTOWN, MANJLAND

31. Dete filed (Month, Day, Year) 32. Registrer's Signeture MAR 23 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ] Certificate of Death 3. Time of Death 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Death **Physician** 8:52P.M 21 Philip Walter Knorr larch /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Baltimore Franklin Square Hospital Cer 7. Age (In yrs. last birthday) enter osedale If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 6. Sex 1 ☑ M 2 ☐ F 5. Social Security Number **Funeral** Months Days 76 218-18-6969 01-24-1923 Director Maryland Usual Residence of Decedent 10d. Inalde City Limita the Merylend 10e State 10b. County 10c. City. Town or Location must be notified at 1 Yes 2 No Director Baltimore Maryland N/A 10a, Citizen of What Country? 10e. Street end Number 10f. Zip Code 4400 Ashcrest Avenue 21206 United States Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. þ 3 Widowed 4 Divorced Yeer or Dates: WWII White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Self Employed Contracting 1 yr. 18. Mother's Neme (First, Middle, Malden Surneme) 17. Fether's Neme (First, Middle, Last) Be Pages 1 end 2 should be a nant of Haalth and Mental Philip R. Knorr Ida M. Biscoe 19e. Informent's Neme/Reletionship (Type, Pnint) 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 4400 Ashcrest Avenue Baltimore, Maryland Theresa M. Knorr / Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Most Holy Redeemer Cem. 3/25/99 Baltimore, Maryland 21. Signeture of Funerel Service Licensee Michael E. Canapp 22. Name and Address of Fecility 5305 Harford Road anago/ LEONARD J. RUCK. INC. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer failure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel Cerebrovascular disease disease or condition resulting in deeth) Examiner Examiner hypertension physician and the burial-transit requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest Mell.70 Division of Vital Records, P.O. Box 68760, Dialets Mell
Due to (or es e consequence of) Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the a should be deteched 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certific 25. Wes cese referred to medical Be 26. Piece of Deeth (Check only one) Hospitel: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA funeral 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Meturel 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completaly filled edical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Day, Year) 29b. Signeture and title of Certifier 29c. License number -un D33634 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) SQUARE DR. #309 BALTIMORE MD ZOUT, UIS 9105 FRANKLIN 31. Date filed (Month, Day, Year) -32. Registrer's Signeture State Registrar



# Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth Month Yeer 1999 2:00 PM March 19 4b. City. Town, or Location of Deeth 4e Fecility Neme (If not institution, give street 4c. County of Deeth HOSPITAL BALTIMORE CENTER HARBOR | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | April 1,1962 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1**X** M 2□ F 36 217-84-9730 Maryland Usual Rasidance of Decedant 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 Tyres 2 □ No Anne Arundel Annapolis 10f. Zip Code 10a. Citizen of Whet Country? 10e. Street and Number 2225 Mulberry Hill Road 21401 USA 14. Rece - American Indian, 12. Was Decedent Ever In U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Bleck, White, etc. tvE Yes 2 □ No If Yes, Give Yaer or Dates:1981-86 Never Merried 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Property Management Real Estate 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Edward William Kaplan Doris Jean Beasley 19a. tnforment's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Edward W. Kaplan (Father) 2225 Mulberry Hill Road, Annapolis, MD 21401 Date 20c. Location - City or Town, Stete 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removel from State MD Veterans Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 03/24 Crownsville, MD 21. Signeture of Euneral Service Licensee 22. Name end Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 Approximete Intervel Between Onset end Deeth 23e. Pert1. Enter the disputer or complications that caused the daath. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart fellows that only one ceuse on each line. Immediate Ceuse (Finel disease or condition resulting in deeth) ANOXIC ENCEPHALOPATHY Due to (or as e consequenca of): 2 DAYS BENZODIAZEPINES Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that Initiated avants resulting in death) Lest ALCOHOL Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert tt. Other etgnificant conditione contributing to daeth but not resulting in the underlying causa given in Part I. 1 Yas 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings evailable prior to completion of cause of daath? 24a. Was an autopsy 1 ☐ Yes 2 LHC 25. Wes cese refarred to medical 26. Plece of Deeth (Check only one) examine ! 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ER/Outpetient 3 DOA 27. Mannar of Death Deta of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Naturel 5 Panding Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be datarminad 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 Homicida

Examiner The law requires that the death certificate be executed the buriel-tran and physician been signed by the should be detach. paga 2 s certificate has Division of Vital or Attending Physician: effar death. Director: After this certific funerai filled in by Hospital 24 hours e

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f shore the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Depertment of Health and Mantal Hygiena. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examina

**Physician** /Medical

**Examiner** 

altimore, Maryland 21215-0020

Director

Funeral

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Completed

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death

Physician/Medical þ Completed Be 2

Certification: Medical 29a. Certifian

(Check only one)

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examtner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29d. Data signad (Month, Day, Year)

29b. Signeture end title of certifiar

March

30. Nama end address of person who completed causa of deeth (Itam 23a) (Type, Print)

BOBAT ISMAIL

3001 S. HANOVER ST. BALTIMORE, MD 21225

31. Date filad (Month, Day, Yeer) State Registrar

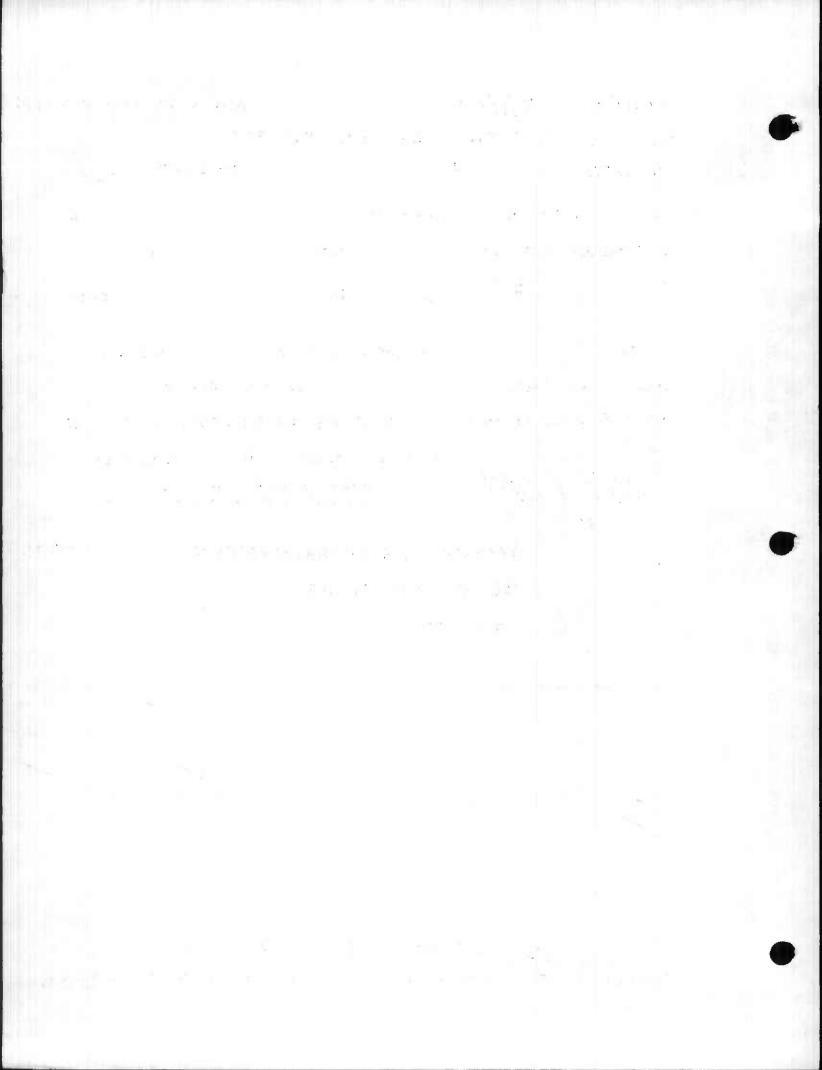
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32. Registrer's Signeture

**DHMH 16 Rev 6/95** 

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pletaly filled in by the funera edical Certification:		nyelclan: To the best of my knominar: On the basis of examination and menner stated.							
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	30. Name and address of person who	Smoleted cause of death (Ite	m 23e) (Type Print)	7	, 5		THUICH	4,1	11.
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YEAR IN

 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** John March 0750 /Medical 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, pr Location of Death 4c. County of Deeth Examiner Randall 5 Town Northwest Hospital Center BALTIMORE If Under 24 Hrs. Hours Min. 7. Age (In yrs. lest birthdey) If Under 1 Yeer Months Deys 5. Social Security Number Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** 1 XM 2□ F Yrs Director 217 22 8116 87 AUG 30 1911 MARYLAND Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Examinar must be notified at MD BALTIMORE Director 1 ☐ Yes 2 ☑ No **FULLERTON** 10e. Streat end Number 10f. Zlp Code 10g. Citizen of What Country? pemit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heelih and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examinat mass 1 once. 112 SIPPLE AVENUE 21236 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. WHITE þ 3 Widowed 4 Divorced Year or Detes: 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PAPER HANGER CONSTRUCTION 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) AGNES C. McEVOY 10 JAMES C. LOGUE 19e. Informent's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA KROPFELDER/DAUGHTER 112 SIPPLE AVE. BALTIMORE, MD 21236 20b. Place of Disposition (Name of 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriai 2 Cremetion 3 Removel from Stete
4 Donation 5 Other (Specify) GARDENS OF FAITH 3-23-99 BALTIMORE, MD 21. Signature of Kuneral Service Licenses 22. Name end Address of Facility CVACH/ROSEDALE FUNERAL HOME 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest shock, or heart failure. List only one cause on each line. 1211 CHESACO AVE. ROSEDALE, MD 21237 Approximete Interval Between Onset end Deeth **Physician** /Medical Immediete Cause (Final disease or condition resulting in deeth) Congestive Heart Failure wee Ks Examiner Examiner attending physician end for usa es the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 dnknown Henorrage 60stron +0thal þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed peen Hypo tenson has 1 Yes 2 No 1 Yes 2 No al or Attending Physician: T s elter death. Il Director: After this certificat ed in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 8 Could not be 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours elf To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner steted. edical 29a. Cartifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 20051301 MO 30. Name and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

North not Hospital Center

32. Registrer's Signature

5401 Old Cour Rd. Ratallosom, Maylund

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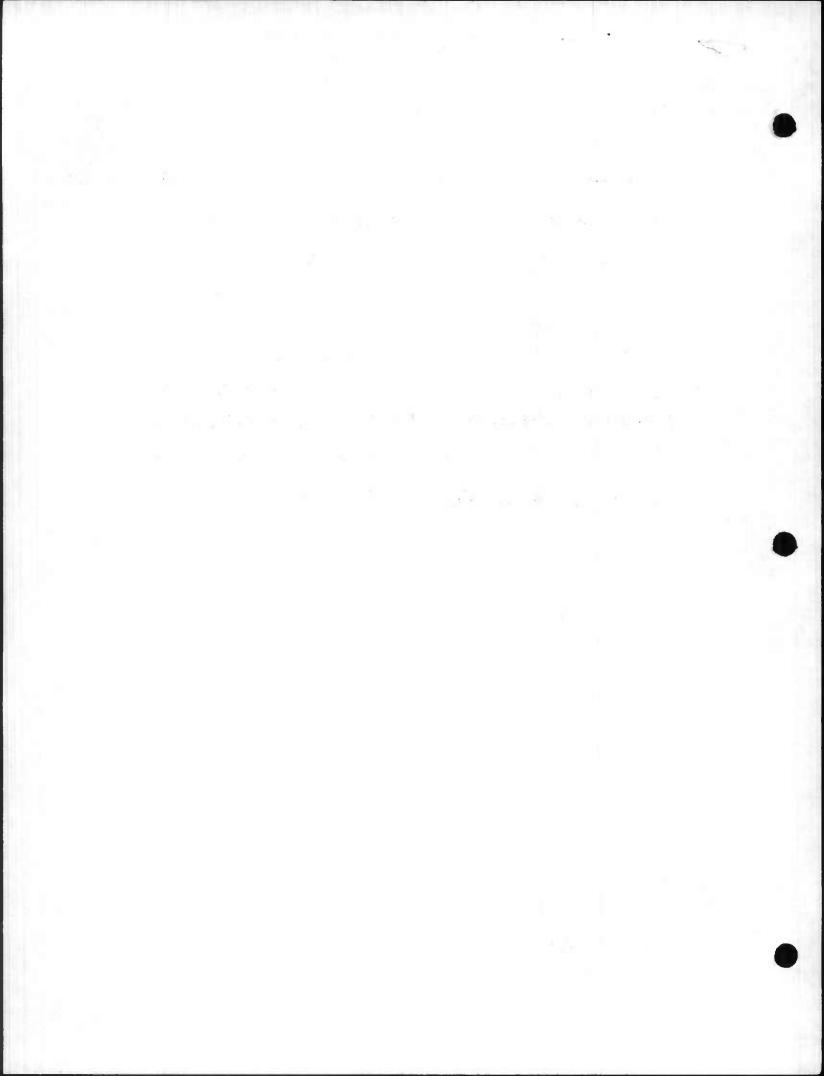
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MAR 2 3 1999



## Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month William E . Lentz Sr. March 20 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Church Hospital N/A Baltimore 5. Social Security Number | If Undar 1 Yaar | If Undar 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 X M 2 □ F 215-18-6763 76 Yrs. June 28 1922 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Dundalk 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34 Vista Mobile Drive 21222 USA 12. Was Dacedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - Americen Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 X Yes 2 □ No If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Foreman Beth - Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph E. Lentz Anna M. Deck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stete, Zip Coda) William Lentz Jr. /son 621 Aldworth Rd Baltimore, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cematery, crematory or other place) Date 20c. Location - City or Town, State March 23 1999 Catonsville, MD 1 ☐ Burlai 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Connelly Funeral Home of Dundalk Conne 7110 Sollers Point Rd 21222 23a. Part1. Enter the disease, or complications thet caused the deathy Do not antar the mode of dying, such as cerdiac or respiratory arrast, shock, or heart fellul. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in daath) Embolism Mulmonary 2 weeks Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Dtd tobacco use contribute to the cause of death? 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown vascular accidents 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Was an eutopsy Schrittere airway disease performed? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case raferred to medical axaminer? 28. Place of Death (Check only one) Hospital: 1 Yas 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yaar) 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed burial-tran ettending physician Division of Vital Records, P.O. signed by d be detect William this certificate Attending Physician: funeral After i or Attendin after death. Director: Aft the

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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**Physician** 

/Medical

**Examiner** 

Physician/Medical

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Completed

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Certification:

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4 Homicide

29b. Signatura and title of certifier

29e. Certifier (Check only one)

Director

Funeral

by

Completed

illed in by 24 hours Hospital

To the

State Registrar

· Advo M 29c. Licensa number 146893

Tertifying Physictan: To the best of my knowledge, death occurred at the time, dete and place, end due to the causa(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Church Home and Hoppital

CLARENCE SARKOBEE - ADOS 31. Date filed (Month, Day, Year)

32. Registrar's Signatura

MAR 23 1999



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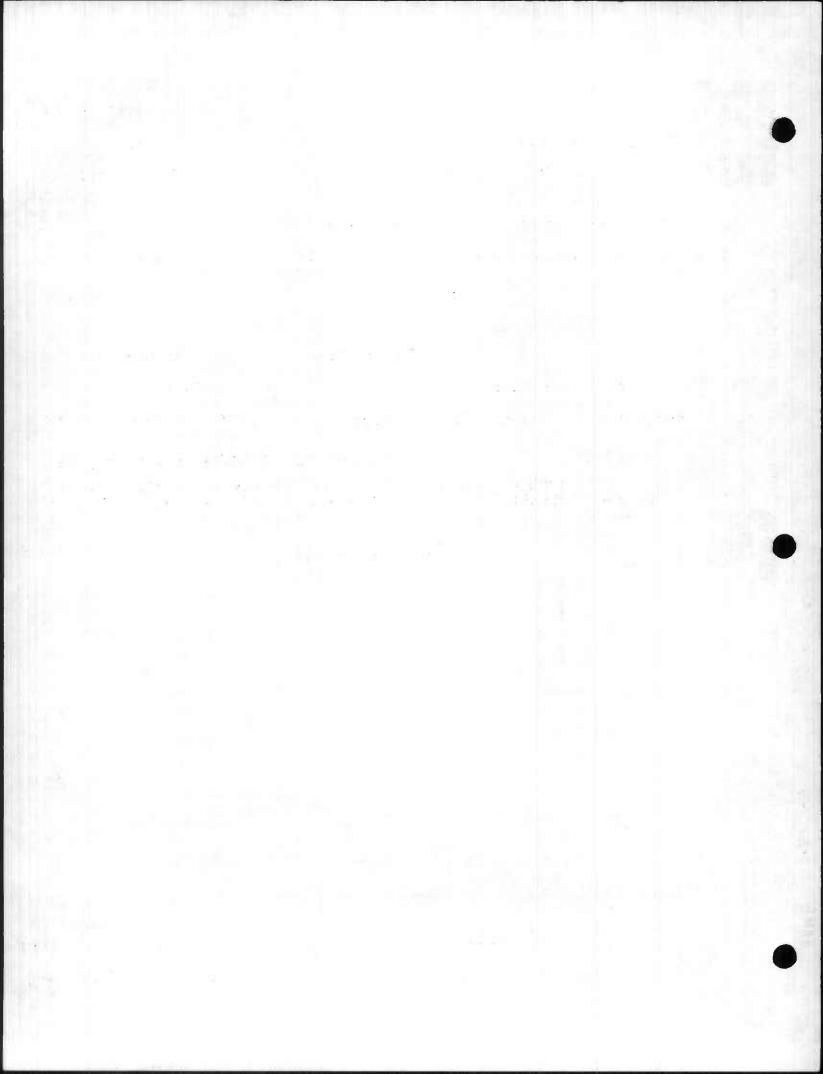
S John March Street

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 0 9 1 2 0 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth **Physician** 1:30 PM Henry A. Miller, Jr. MARCH 20 1999 /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not Institution, give street and number) 4c. County of Deeth Examiner St. Agnes Hospital Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number If Under 1 Yeer 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** ₩ 2□F Months Deys Yrs. 215-14-4704 76 Director DEC 10, 1922 Maryland Usuel Residence of Decadent the Merylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Baltimore Catonsville 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 709 Maiden Choice Lane 21228 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 (X)Yes 2 □ No If Yes, Give WW II Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or item eny Injury or other traumatic event, the Mexical Examples 2006. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineering Manufacturing 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Henry A. Miller Carrie Karl 19e. Informent's Name/Reletionship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine M. Miller/wife 715 Maiden Choice Ln., CR607 Catonsville, MD 21228 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State Metro Crematory, Inc. 4 □ Donetion 5 □ Other (Specify) 03/22/99 Baltimore, MD 22. Name end Address of Fecility
Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228 21. Signeture of Funeral Servica Licenses A Dawn F. McDonald 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician Immediete Cause (Finel diseese or condition resulting in deeth) /Medicai PNEUMONIA 2 weeks Examiner Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Lest and Due to (or as e consequence of) Box 68760. physician Physician/Medical the Due to (or as a consequenca of) USB Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Was an autopsy performed? Completed 98 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending 1 Yes 2 No Investigation 2 Accident efter deeth Director: 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide ŏ 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the ceuse(s) end manner as stated.

2 Madical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) end menner stated. 29a. Certifie (Check only one) To the To the F 29b. Signature and title of cartifier 29d. Date signed (Month, Dey, Year) 46704 MARCH 20, 1999 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) AGNES HOSPITAL BUT MD MUTOMBO KANKONDE 32. Registrer's Signature 31. Dete filed (Month, Dey, Year) 2 3 1999 Registrar

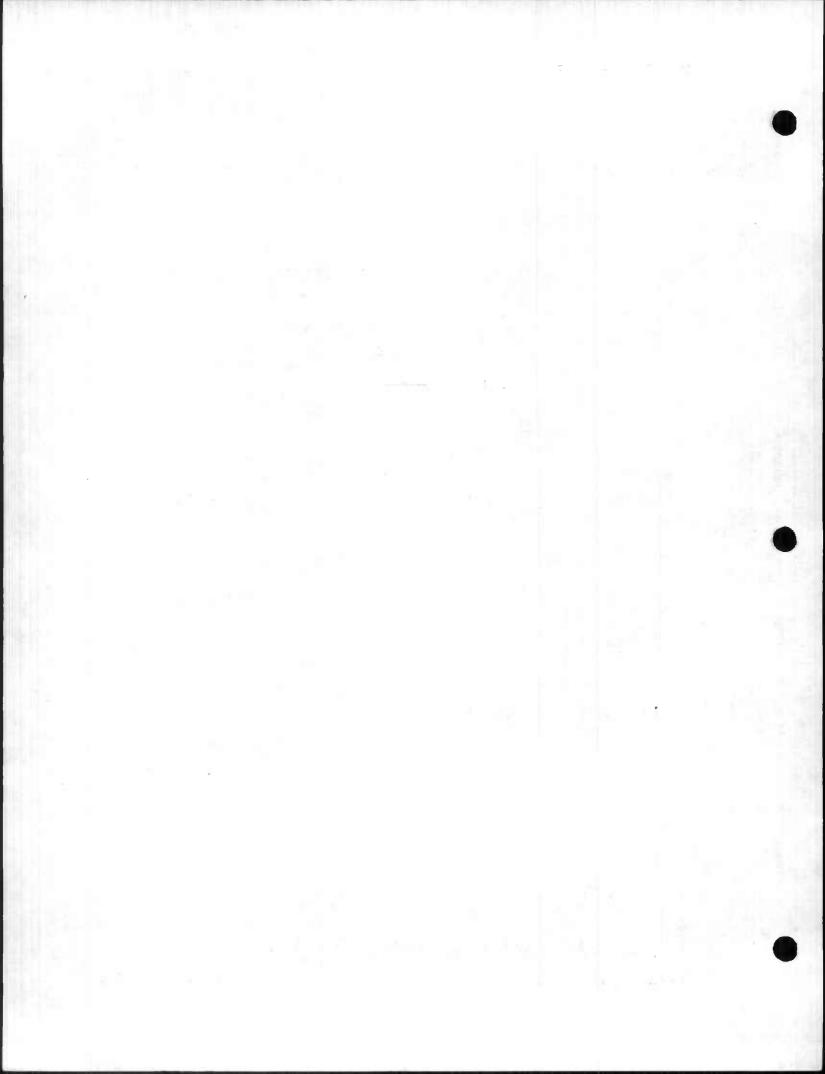
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State of Manyland / Department of Health and Mantal His	
State of Maryland / Department of Health and Mental Hy	/giene

Item:17, per F.H. G-7		Ce	rtificate	e of l	Death		Reg. I	No. 9	9 0	15:16		
Decedent's Name (First, Middle, L. SULAMITH	ast)		M	EHLE	R	2. Date of Month		1999	Year	3. Time of Death 3:40 PM		
4a Facility Name (If not institution, gi		4		or Location of E	eath 4c. County of Death							
17 CLOVELLEY STF 5. Social Security Number 6.		yrs. last birthday	) If Under	1 Year		BALTIMORE  f Under 24 Hrs.   8. Data of Bir			BALTIMORE  9. Birthplace (State or Foreign			
	10 M 20 F	93 Yrs.	Months	Days	Hours A	Ain. 8. Data of (Month SEPT	12,1	905		SLOVAKIA		
Usual Residence of Decedent 10a. State 10b. County	140-	Ch. Tour cal	tion			1			404	1. 1. 0. 1. 1.		
		City, Town or I							100	Inside City Limits  1 ☐ Yes 2 🔀 No		
MD BALTIM	IORE	BALTIMOF	10f. Zip	Code			10a. 0	10g. Citizen of What Country?				
17 CLOVELLEY STR	REET				2120	38		U.S.	.A.			
11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates;	in U,S. 13.	Was Deced If Yes, spec		ispanic Origina n, Mexican, Pi Specify:	(Specify Yes o perto Rican, etc.	No-		ce - American ck, White, etc y: WI			
15. Decedent's E	ducation	16a. Deci	ation		16b.	Kind of B	usiness/Indu	stry				
(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	(Giv life. ATTOF	k done d se retired	during most of f)	working	LA	W					
7. Father's Name (First, Middle, Las MOSHE	LEWIN	<del>L</del> EW					ddle, Maid	Maiden Surname) SCHICK				
19a. Informant's Name/Relationship GEORGE MEHLER /						Rural Route N BALTIMOI				ode)		
20a. Method of Disposition  1 Buriaf 2 Cremation 3 4 Donation 5 Other (Speci	Removal from State	SHARON GAR			r other place)			Data 20c. Location - City or Town, St. 721/99 VALHALLA, NY				
21. Signature of Funeral Service Lice							NSON & BROS., INC. - PIKESVILLE, MD 21208					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	to (or as a conse					45					
	d											
Part II. Other significant conditions	Dement	underlying ca	en in Part I.		3b. Did tobacco use contribute to the cause of deat 1 Yes 2 No 3 Probably 4 Volkno			,				
							Was an au performed		avaik	autopsy findings able prior to eletion of cause ath?		
							I ☐ Yes	2 0 No	101	res 2□ No		
25. Was case referred to medical examiner?	Hospital:			Oth	or	Death (Check o	1					
1 Ves 2 Ves 10 Ves 27. Manner of Death 1 Ves 10 Ves	28a. Date of Injury (Month, Day Yea	2 ER/Outpation 28b. Time Injury	of 2	8c. Injur	y at k?	28d. Desc						
2 Accident investigation 3 Suicide 6 Could not to detarmined	28e. Place of Injury -	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Roc City or Town, Stata)		loute Number,			
29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of my miner: On the basis of exar and manner stated.	knowledge, dea nination and/or i	th occurred a nvastigation,	at the tin	na, data and pl pinion, death o	ace, and due to	the cause me, data i	e(s) and m and place,	anner as stat and due to th	ed. ne cause(s)		
29b. Signature and title of certifier	0	BER	29c		e number		29d. I	Date signe	ed (Month, De	y, Year)		
Davida	Lindia	11 ru	7	D	30119		31	19/0	79			
30. Name and address of person who	completed cause of death	(tem 23a) (Type	Print)	KE	2116	LE RO	AD	2	1284			
31. Date filed (Month, Day, Year) MAR 2. 3 1999	32. Registrar's S	ignature	-	-					1			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month CHRISTOPHER MARKELL 9:30 AM Masch 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Pediatric Houpidal BALTIMORE Washington Number 6 Sax N/A If Undar 1 Yaar Months Days 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) M 2□ F 14 MD Usual Rasidanca of Decedant 10c. City, Town or Location
Baltimore 10a. Stata 10b. Count 10d. Insida City Limits N/A MD ¶Yas 2□No 10f. Zip Coda 21224 3204 Fleet St. 10g. Citizan of What Country? 12. Was Dacadant Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Navar Married 2 ☐ Married 1 ☐ Yas 2√7 No If Yas, Give 1 Yaar or Datas: 1 ☐ Yas 2 No Specify: white 3 Widowed 4 □ Divorced 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Collaga (1-4or 5+) Elamentery/Secondary (0-12) N/A N/A 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surneme) Glenn M. Markell Dawn M. Wiegel 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) 3204 Fleet St. Baltimore, MD Glenn Markell/father 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Othar (Specify) 3-22-99 Crestlawn Cemetery Marriottsville, MD 21. Signatura of Funaral Sarvice Licensee 22. Name and Address of Facility
Cvach/Rosedale Funeral Home 1211 Chesaco Ave., Rosedale, MD 21237 23a. Part1. Enter tha disaasa, or complications that causad the daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on sech line. Approximata Intarval Batween Onsat and Death Immediate Causa (Final PNEUMOMA

Due to (or es a consequence of): disaasa or condition rasulting in daath) PULMO MARY

Dua to (or es e consequence of) Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury thet initiated evants rasulting In daath) Łast 10 haur BRADYCARDIA 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PROGRESIVE ENCEPHALOPATHY 24b. Were eutopsy findings availebla prior to complation of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No 28. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 1☑Inpatiant 2□ER/Outpatient 3□ DOA 28a. Data of Injury (Month, Day Year) 28h Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? 5 Panding Invastigation 1 Tas 2 No 6 Could not ba

Physician/Medical Examiner physician and s the burial-transit Box 68760, Records, P.O. þ Completed Division of Vital To the Hospital or Attanding Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director, it Be Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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Hems

Director

Funeral

by

Completed

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f is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at

"natural", or

permit. Pagas 1 and 2 should be flied within 7 Departmant of Haalth and Mantal Plygiene. Important: if item 27 is marked other than "r any injury or other traumetic event, the Mad pones.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Part II. Other significant conditions contributing to death but not rasulting in the undarlying causa givan in Part I. 25. Was case referred to madical axaminar? 1 Yas 2 No 27. Mannar of Death 1 Natural 2 Accidant 3 ☐ Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 ☐ Homicida Decrifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the bests of axamination and/or invastigation, in my opinion, death occurred at tha time, deta and place, and dua to the causa(s) and mannar statad. 29a. Cartifiar (Check only one) 29b. Signetura and titla of certifiar 29d. Data signed (Month, Day, Yaar)

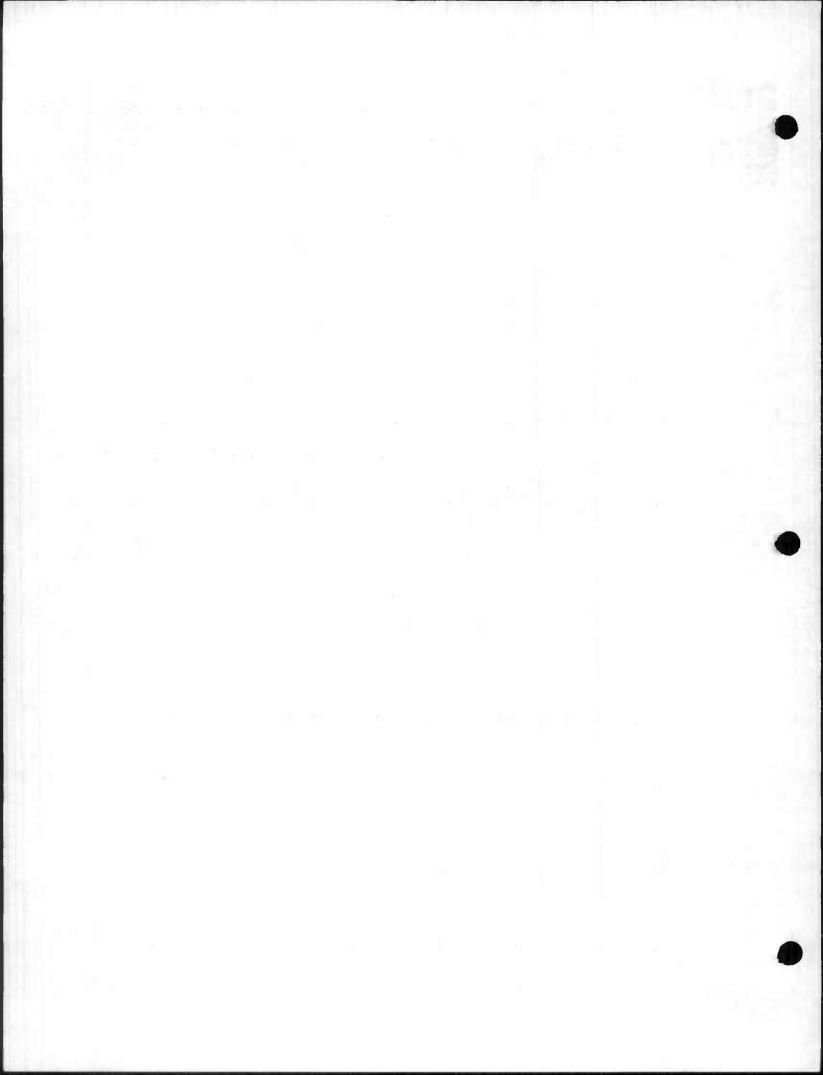


31. Data filad (Month, Day, Year) 32. Ragistrar's Signatura MAR 23 1999

30. Name end eddress of person who completed causa of daath (Itam 23a) (Type, Print)

Kustana

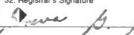


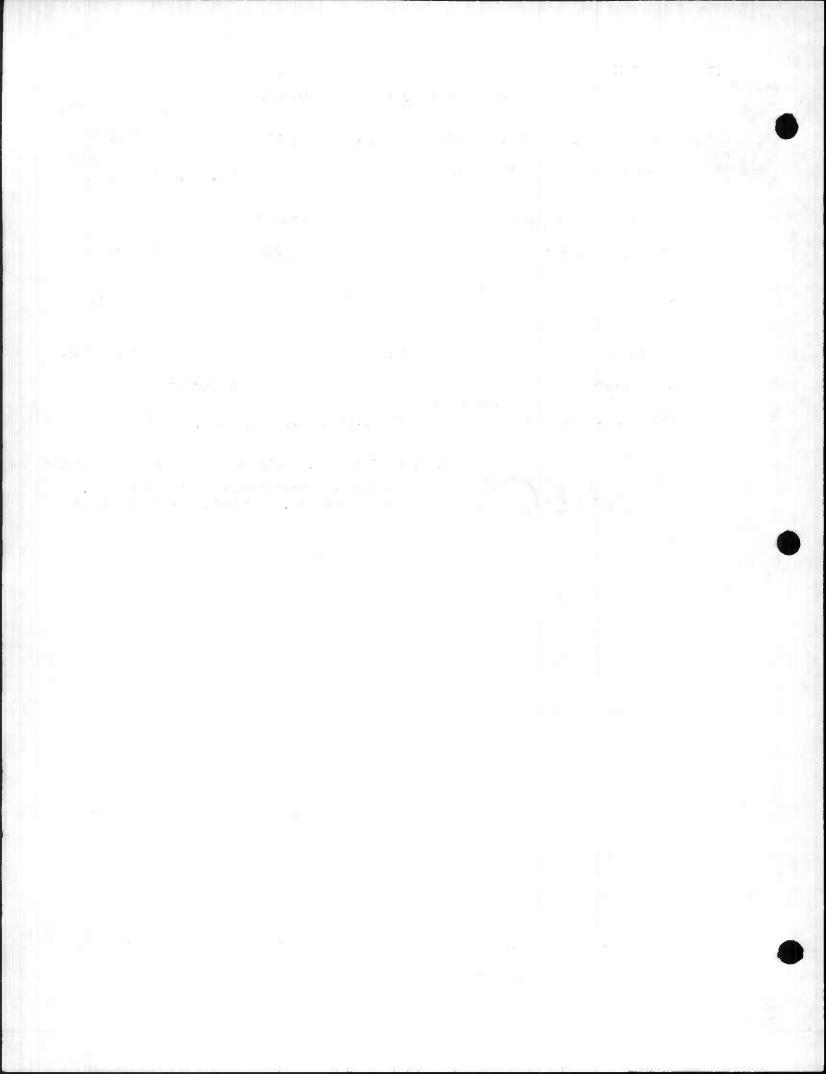


State of Maryland / Department of Health and Mental Hygiene ITEM: #23 PART II PER MD G769 3-23-99 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Daath 3 Time of Deeth Misciwojeski Sophia Catherine Month **Physician** March 20, 1999 12:25 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Heritage Meridan Eldercare Ctr. Dundalk Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 ☐ M 2 ☐ F 215-05-7576 Yrs. Director 94 Oct. 12,1904 Maryland Usual Residenca of Decedent Manyland 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk tha 10e. Street and Number 10f. Zip Coda 10a. Citizen of Whet Country? 7310 Stratton Way 21224 United States death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mantal Hygiena.
Important: If item 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Examines. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes ŽÍNo Specify: Specify: by White **¾**□ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Years Cook Food Preparation 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Siwak Anna Cholewinska 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Dolores A. Ostrowski 7310 Stratton Way Dundalk, Maryland 21224 20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, crematory or other placa) 20c. Location - City or Town, Stete 2 Cremation 3 Removal from State 5 Other (Specify) 1 Buriel Donati St. Stanislaus Cem. 3/23/1999 Dundalk, Maryland of Funeral Service Lie 22. Name end Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Partiventar the disease, or complications that eaused the death. Di not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Dundalk, Maryland 21222 Approximete Intarval Between Onset and Deeth **Physician** /Medical Immediate Causa (Final ALZHEIMERS 8 483 DISTASE disease or condition resulting In death) **Examiner** Due to (or as a consequence of) Examiner Sequentially list conditions, if eny, laading to immadiata cause. Enter Underlying Cause (Diseasa or Injury that initiated evants resulting in death) Last physician end s the bunal-tran Due to (or as a consequance of): be exec 68760 Physician/Medical Due to (or as a consequenca of): 88 Box attending esn for P.O. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t FENDROL FRACTURE. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Records, þ been sig 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yas 2 No certificata 1 Yes 2 No Division of Vital Be 25. Was case raferred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 this funaral 27. Mannar of Death 28a. Date of injury (Month, Day Yaar) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending Investigation 1 Natural Injury al or Attending s after death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) by 4 I Homicida To the Hospital owithin 24 hours aff To the Funeral Di completely filled in 1 Decertifying Physician: To the best of my knowledga, daath occurred at the tima, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the causa(s) and manner statad. edicai 29a. Certifier (Check only one) 29b. Signature and title 29d. Date signed (Month, Dey, Year) 29c. License number 7753 maying, 30. Nama and address of parson who completed causa of daath (Itam 23a) (Type, Print) K.S.DHARMASENA, M.D. 7/OCHWECH ST. BALTIMORE, MD 21228 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

MAR 2 3 1999

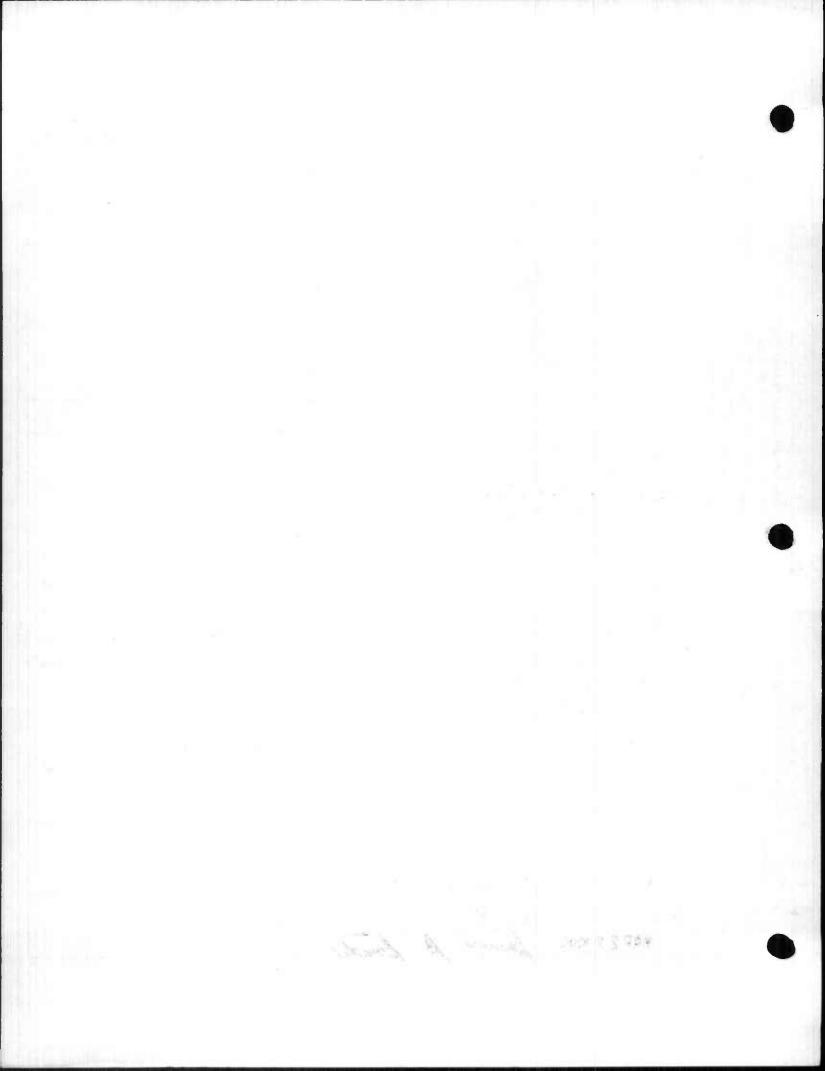




DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit narmin Pages 1.2 should	is after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.	n 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL DR ATTENDING PHYSICI	THE FUNERAL DIRECTOR: After this cert	be filed within 72 hours after death with the	IMPORTANT: If item 28 is marked, o

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF	HEALTH AI	ND MEI	NTAL HYGIENE REG. NO.		0 54 6 4			
	1. DECEDENT'S NAME (First, Middle, Lest)	E. Mille				2.	DATE OF OEATH DAY	YEAR	3. TIME OF OEATH			
	8. BIRTH	PLACE (State or Foreign										
TOR	9a. FACILITY NAME (If not institution, give st 118 Haven Road RESIDENCE OF DECEDENT	reet and number)			on Location Denton	OF DEATH	9c.	Caroli				
DIRECTOR	10e. STATE 10b. COUNTY	imore		y, town on Lo					10d. INSIDE CITY LIMITS? 1  YES 2 NO			
FUNERAL	100. STREET AND NUMBER 7331 Windsor Mil				2124	Ą	109		States			
B⊀	11. MARITAL STATUS 1 Never Married 2 Married 3 Never Married 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAR OR DAT	2 -NO	If yes,	specify Cuban, N	ISPANIC O lexican, Pu Specify:	RIGIN? (Specify Yes or No erto Rican, etc.)	14. RACE Black Speci	- American Indian, White, etc.			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	18a. DECEDENT'S (Give kind of v life. Do NOT us HOMEMA	vork done during e retired.)	FION most of working		166. KIND OF BUSINES					
NO.	17. FATHER'S NAME (First, Middle, Last)		Homema	IVET	40 MOTHER	O NAME O	First, Middle, Maiden Suma					
S I	Lee Zimmerman						nknown	me)				
TO BE	19h. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street			Number, City or Town, Stat	te, Zip Code)				
F	George Miller, Jr	. (Son)	9 But	ler Ro	ad Reis	ters	town, MD 2	1136				
	20s. METHOO OF DISPOSITION 120 Burlel 2 Cremation 3 Remo 4 Donation 8 Other (Specify)		PLACE AND DATE C	e Cemet	ery		3/24/99 Rand	N - City or To	own, MD			
	21. SIGNATURE OF FUNERAL SERVICE LIC	while					Ambrose Fu		Home , MD 21227			
	23. PART i. Enter the diseases, or c	omplications that caused	the death. Do n	ot enter the r	node of dying,	such as	cardiec or reapirator	y arreat,	Approximata			
	iMMEDIATE CAUSE (Final disease or condition resulting in death)			dial	Ir	fa	retion		Interval Between Onset and Death			
NO	Sequentially list conditions,	Dehy	dati	en .					4 wks			
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A C	CONSEQUENCE OF	tia					4000			
	resulting In death) LAST											
DICAL	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS PERFORMED?  1 VES 2 100  1 VES 2 100  1 PERFORMED?  1 VES 2 100  1 PERFORMED?											
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	ilens							1 YES 2 NO			
SICI	EXAMINER?	HOSPITAL:	tlent 3 DOA	OTHER:	me 8 Reside	V	A	Tichen	Line			
	27. NANNER OF DEATH  1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	E OF 28c. I	JURY AT PORK?	28d	Other (Specify)  OEŞCRIBE HOW INJURY	OCCURED	LIVING			
TED BY	2 Accident Investigation 3 Suicide 8 Could not be datermined	28a. PLACE OF INJURY - building, etc. (Specif)	- At home, farm, s			-	LOCATION (Street and Nu City or Town, State)	mber or Rural R	oute Number,			
COMPLETED		EAN: To the best of my knowled: On the basis of examination							and manner as stated.			
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	eno11	RN	-	29c. LICENSE				(Month, Day, Year)			
	30. NAME AND ADDRESS OF PERSON WHO	ett po	BOX (	Print)	Den	tor	, mo	2162	.9			
	MAR 2 3 1999	32, REGISTRAR'S SIGNAT	B.	back								



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

MEDU	RA
	Dhusisian
1	Physician
	/Medical

Examin

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylen Department of Heelth and Menlel Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Macical Examiner must be notified at once.

Physician /Medical Examiner

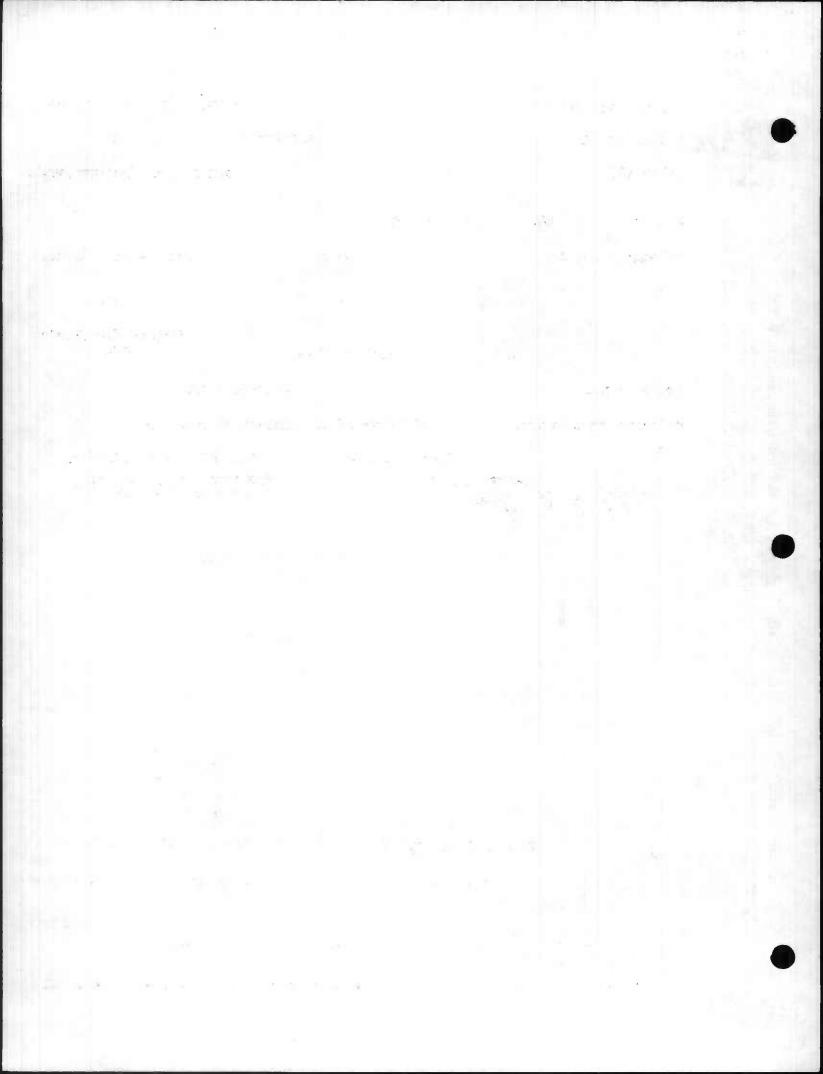
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

	1. Decedant's Nam	na (First, Middl	a, Last)								2. Data of D				3. Tin	na of Death
n	Richard Par	trick Med	dura								MARCH					00P.M.
al er	4a Fecility Name (	'If not institution	n, give street end	nu <i>mber</i> )					4b. City, To	wn, or L	ocation of Dee			y of Deat	h	
	915 S.ELI	LWOOD A	VE						BALT	IMOF	RE			N/	Ά	
	5. Social Security N 212-60-967		6. Sax 1 □ X M 2 □ F		45 45	ast birthday) Yrs.	If Unda Months	r 1 Year Days	If Undar Hours	24 Hrs. Min.	8. Data of Bi (Month, D August	irth ay, Yea 31, 1	953	Co	untry)	ata or Foreign Marylan
	Usual Rasidence of Decedant           10a. Stata         10b. County         10c. City, Town or Low														10d. Insid	da City Limits
Ö	Maryland		N/A							1 🔯	Yes 2□No					
2	10e. Street and Nu	ımber					10f. Zij	p Coda				10g. C	itizen of	What Co	untry?	
2	915 South	Ellwood	Ave.					2122	4		- 1	Unit	ed St	ates	of Ame	erica
5	11. Marital Status		12. Wes D	ecedent l Forcas?	Ever in U,	S. 13.	Was Dace	dent of I	Hispanic On	igin? (Sp	pecify Yes or No Rican, atc.)	0-		ce - Ama	ricen Indie	n,
be completed by I allelan billecto	1 ☑ Nevar Man 3 ☐ Widowed		ried 1 ☐ Ya If Yas,	s 2X	No		1 □ Yas				o riiouri, ato.,		Speci		ite	
201	/Sna	15. Dacedan	t's Education st grada complate	d)		18a. Deced	dent's Usu	al Occu	pation during mos	t of wor	kina			Businass/		
dillo	Elamantary/Sec			a (1-4or 5	i+)	'lifa.	lectio	ısa ratire	ed)			Ba	ltimo	re Ci Board		ection
	17. Fathar's Nama	(First, Middla,	Last)						18. Motha	ar's Nam	na (First, Middle	e, Maide	n Suma	ma)		
	Kassimer M	edura							Marie	e Ann	Dzerzins	ski				
	19a. Informant's N	lame/Ralations	thip (Type, Print)			19b. Mailir	ng Addras	s (Stree	t and Numb	er or Ru	ral Routa Numi	ber, City	or Town	, Stata, 2	(ip Coda)	
	Mr.Stephen	Medura(1	Brother)			5702 E	inderly	y Roa	d Bal	timo	re, Mary	land	2121	2		
	20a. Mathod of Dis	P				laca of Dispo					Date				Town, Sta	ta
	1 ₺ Buriai 2 4 □ Donation		3 □Ramoval fro pecify)	m Stata	0ak	Lawn C	emeter	ry		3	/23/1999	Bal	timor	e, Ma	ryland	t
	21. Signeture of Pr	uneral Service	Licensee Jeff	rey L	. Gair	22	2. Nama a	nd Addr	ass of Fecili	ty Ruc 105	k Towson 0 York Ro	Fune	ral F wson,	lome, Md.	Inc. 21204	
	Immadiata Causa disaasa or conditio rasulting in daath)  Sequentially list or if any, laading to incausa. Entar Und	onditions, mmadiata arlying	e		Dua to (o	r as a consecutive	quance of)	):	V1W)_	OF	HUDO			1	Olisat	end Death
	that initiated evant rasulting In daeth)	S	d		Due to (or	as e conseq	uence of):	:						1		
	Part II. Other signi	ficant condition	one contributing to	death b	ut not rasu	ulting In tha u	ndarlying	causa gi	ivan In Part	l.	23b. Dic	tobaco	o use c	ontribute	to the ca	use of death?
											10	Yes	2 No	3 🗆 Pi	robably	4 Unknow
											24a. Wa per	formed?	opsy 7 2 DNo		avallable p complation of death?	psy findings prior to n of causa
	25. Was casa rafa	rred to medica								e of Dea	ath (Check only	ona)				
	↑▼ Yas 2□			☐ Inpatia		ER/Outpatier		OA		ursing H	oma 5 TRas				city)	
	27. Mannar of Dea 1 □Natural 2 □ Accident	5 Pandir invasti	gation FOCIMO	ta of Injudonth, Day		28b. Tima o Injury	P M	28c. Inju Wo 1	ıryat ork? ]Yas 2.⊠	No	SIN'S				S छा	K.
	3 Suicida 4 ☐ Homicida	6 ☐ Could datam			ury - At ho . (Specify	ome, farm, str	eet, fector	ry, office			28f. Location City or To	own, Sta	afa)			
	29a. Cartifiar (Check only one)		ng Physician: To Examinar: On the	tha best o	of my know	wladga, daatl					, and dua to the	a causa	(s) and n	annar as		
-	29b. Signature end	d title of certifie		umidi Sit			29	c. Licen	se number			29d. [	Data sign	ed (Mont	h, Dey, Ye	ear)
	Mai	we !	melka	ul	/	om			C.M.E	•				9,19		
	30. Nama and add	Dring	S.KC	MEL	aath (Itam L ar's Signa			Pen	n Str	eet,	Baltin	nore	, Ma	ryla	ind 2	1201

State Registrar



# Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month Day Physician JOHN WAGNER MORLEY MARCH 8,1999 9:00 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner SHADY GROVE ADVENTIST NURSING HOME ROCKVILLE MONTGOMERY If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month. Days Hours Min. JUNE 3, 1909 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 6. Sax **Funeral** 10 M 2□ F PENNSYLVANIA Yrs 095-10-1650 89 **Director** Usual Residence of Decedent with the Maryland r 28a-f show 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Directo MARYLAND ROCKVILLE MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be r 20850 UNITED STATES Funeral 9701 MEDICAL CENTER DRIVE Pages 1 and 2 should be filed within 72 hours after deathnent of Health and Mentel Hygiene. 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amarican Indian Bleck, White, atc. 1 Navar Marriad 2 N Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced r than "natura Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) CARTOONIST ART ed other 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meiden Sumama) Be 7 is merked of traumetic ev MABEL WAGNER ARTHUR MORLEY 19a. Informant's Name/Ralationship (Typa, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Coda) Health m 27 1790 LOS PUEBLOS LOS ALAMOS, NM 87544 LYNN MORLEY GODWIN/DAUGHTER item 2. 20b. Place of Disposition (Nama of cematery, crametory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cramation 3 ☐ Ramoval from Stata = 5 permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Othar (Specify) 03/19/99 BRENTWOOD, MD FT. LINCOLN CREMATORY 22. Nama and Addrass of Facility HINES-RINALDI FUNERAL HOME 21. Signature of Funeral Sarvice Licansaa 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. SILVER SPRING, MD 20904 Approximate Interval Batwaan Onset and Death Physician Immediata Causa (Final disaasa or condition rasulting in daath) /Medical PROSTATE CANCER - METASTATIC YEARS Examiner Dua to (or as a consequance of): Examiner physician end s the buriel-transit that the death certificate be executed Sequentially list conditions, if any, laading to immadiate ceuse. Entar Undarlying Cause (Diseasa or Injury that initiated avants resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequance of): 20 Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yes 2 ☐ No 3 □ Probably XIX Unknown STROKE Records, p 24b. Wara autopsy findings available prior to 24a. Was an autopsy Completed MACULAR DEGENERATION complation of causa of daath? s certificate hes t director, pege 2 s PERIPHERAL VASCULAR DISEASE 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physician: director 25. Was cese referred to medical axaminar? Be 26. Place of Death (Check only ona) ASSISTED Other: 4 Nursing Homa 5 Rasidence 6 NOther (Spacify)LIVING 1 Yas 2 X No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mannar of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: After s after dea. 1 XNatural 5 Pending 1 Yas 2 No Invastigation 2 Accident 3 Suicida 6 Could not be 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Spacify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Confirm Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

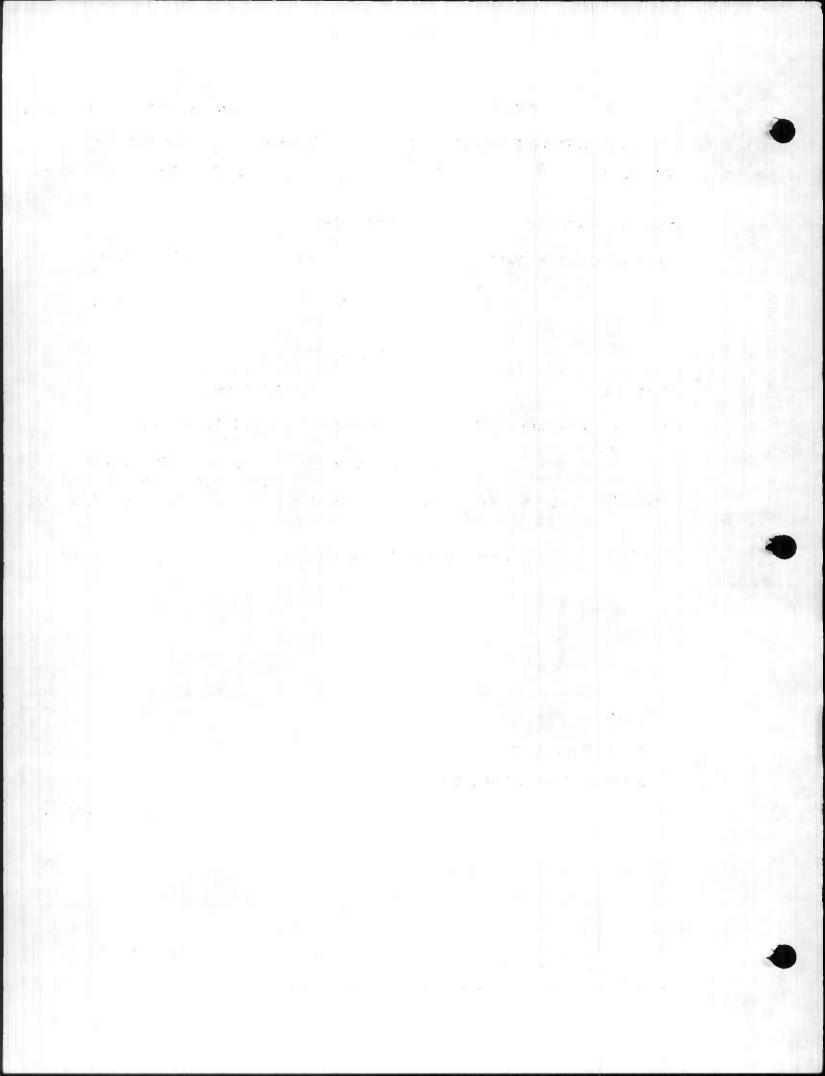
Continued by the cause(s) and manner as stated.

Continued by the cause(s) and manner stated.

Continued by the cause(s) and manner stated. 29a. Cartifier edicai (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura filtie of 29c. Licansa number MARCH 9,1999 D 28656 30. Nama and address of p complated ceusa of death (itam 23a) (Type, Print) RAVI PASSI, M.D. 8609 SECOND AVE. #404B SILVER SPRING, MD 20910 31. Data filed (Month, Day, Yaar) 32. Ragistrar's Signature State

Registrar

MAR 23 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month MCCLAM 18:13PN OEAL 1999 20 4b. City, Town, or Location of Death 4a Facility Name (ff not institution, give street and number) 4c. County of Death BALTIMORE HOSPITAL HOPKINS OHNS If Under 24 Hrs.
Hours Min.

8. Data of Birth
(Month, Day, Year)
May 19,1922 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (fn yrs. last birthday) 10M 2DF Months Days 248-28-5303 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits BALTionore NA 1 Yas 2 No MUD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21205 USA Street low 1025 N 72. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Ricen, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, atc. 1 ☐ Never Married 2 ☐ Married 1 Yas 2 PNo Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) rucking 4th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) buc Clam JONES Laura wife 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cometery, crematory or other place) BALTIMONE, MD. 21205 McClam Louise WashingTon St 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 3-26-99 RandolsTown, MD. 4 ☐ Donation 5 ☐ Other (Specify) Mem Park Albert P.WYLie 22. Name and Address of Facility 21. Signature of Funeral Service Licensee St BATTIMONE, MD. 21217 Gilmor Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or ahock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death JEPS13 Immediate Cause (Final disease or condition resulting in death) RINARY RACT Due to (or as a consequence of). DRATION Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yee 2 No 3 Probably 4 Unknown TANHIPOPITUITARISM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? FNLARGEMENT 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how Injury occurred

**Physician** /Medical Examiner physician end the buriel-transit The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760,

for use es

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peen

ils certificate has b

this After this

or Attending Physician:

death. Director: A

To the Hospital or A within 24 hours effer To the Funeral Direcompletely filled in b

Examiner

Physician/Medical

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**Physician** 

/Medical

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Director

the Marylend

permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mentel Hygiene. Important: if Item 27 is marked other than "naturel", or items 23s or 28s-f show way lajury or other treumstic svent, the Medical Exocitest transitional page.

Baltimore, Maryland 21215-0020

Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

PROSTATE

1 Yes 2 XNo 27. Manner of Death 1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending Investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

1 Certifying Phyeicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

Lusin Rae Vagner, MD

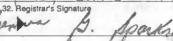
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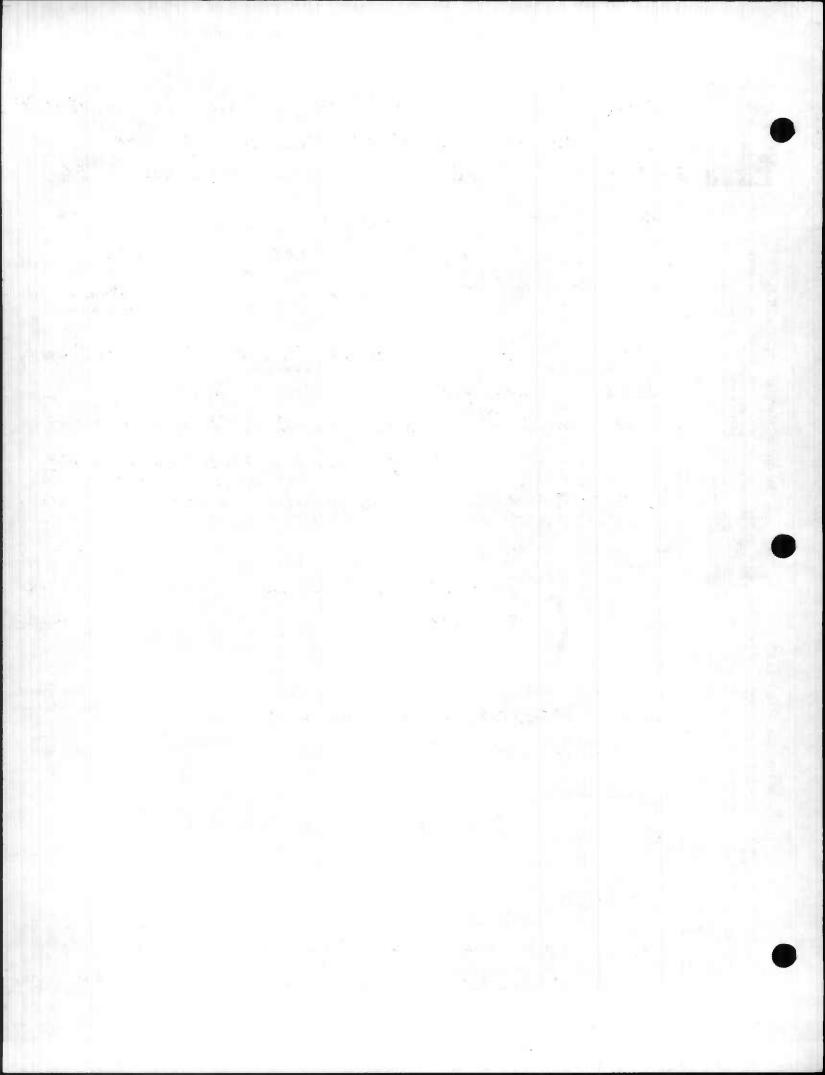
MARCH 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. DALTIMORE MD. 21287 KAE WAGNER HOSPITAL KRYSTAN JOHNS HOPKINS 31. Date filed (Month, Day, Year)

State Registrar





99-1670-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

**JAMES** 

State of Maryland / Department of Health and Mental Hygiene

NJ	Physici: //Medic Examin	al
	Funeral Director	

Division of Vital Records. death.

Item 20b Per FH FilmG769 3-31-99 rja Certificate of Death 2 Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 19,1999 MARCH 10:15P.M. James Alexander Nichols 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) 852 GLADE COURT BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) Deys Hours 11XM 2□ F Yrs. 43 212-70-4725 12/10/1955 Maryland Usual Residence of Decedent 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Yes 2 No Director Maryland Baltimore 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 21226 313 Cherry Hill Road Funeral U.S.A. 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus e filed within 72 hours after al Hygiena. other than "natural", or ite 1 Yes 2 No 1 Never Merried 2 Married 1 Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None Unemployed 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 12 should be fine of the first 0 James Nichols Llewelyn Walker 19a. Informent's Name/Reletionship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 sh Department of Health end Important: If Item 27 is m any Injury or other traum pncs. 2809 Kinesy Ave., Baltimore, Maryland 21223 Janice Nichols / Wife 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete Dete 29 1 N Buriel 2 □ Cremetion 3 □ Removel from State 03/<del>26</del>/99 Landsdowne, Maryland Mt. Zion Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Servica Ligensee The Derrick C. Jones Funeral Hm. 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Pert1. Enter the disease, or complications that shock, or heart feilure. List only one cause on the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, Approximete Intervel Between Onset end Death Physician Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Examiner g physician and as the burial-transit Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): Box 68760 Physician/Medical Due to (or es e consequença of) the ettending usa P.O. be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 217 No 3 Probably 4 Unknown signed by by 24b. Were eutopsy findings evellable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed certificate has 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify SCENE 1 X Yes 2 □ No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Menner of Death 28b Time of Certification: 28c. Injury et Work? 1 Neturel 5 Pending investigation 28e. Pleca of Injury - At hon building, etc. (Specify) Stell 200 1 Yes 2 Accident after death 6 Could not be determined 3 ☐ Suicide At home, ferm, street, factory, office (Street and Number or Rural Route Number Momicide State) Le 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner stated. 29a. Certifie edical one) To the To the F 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year) MARCH 20,1999 O.C.M.E.

Registrar

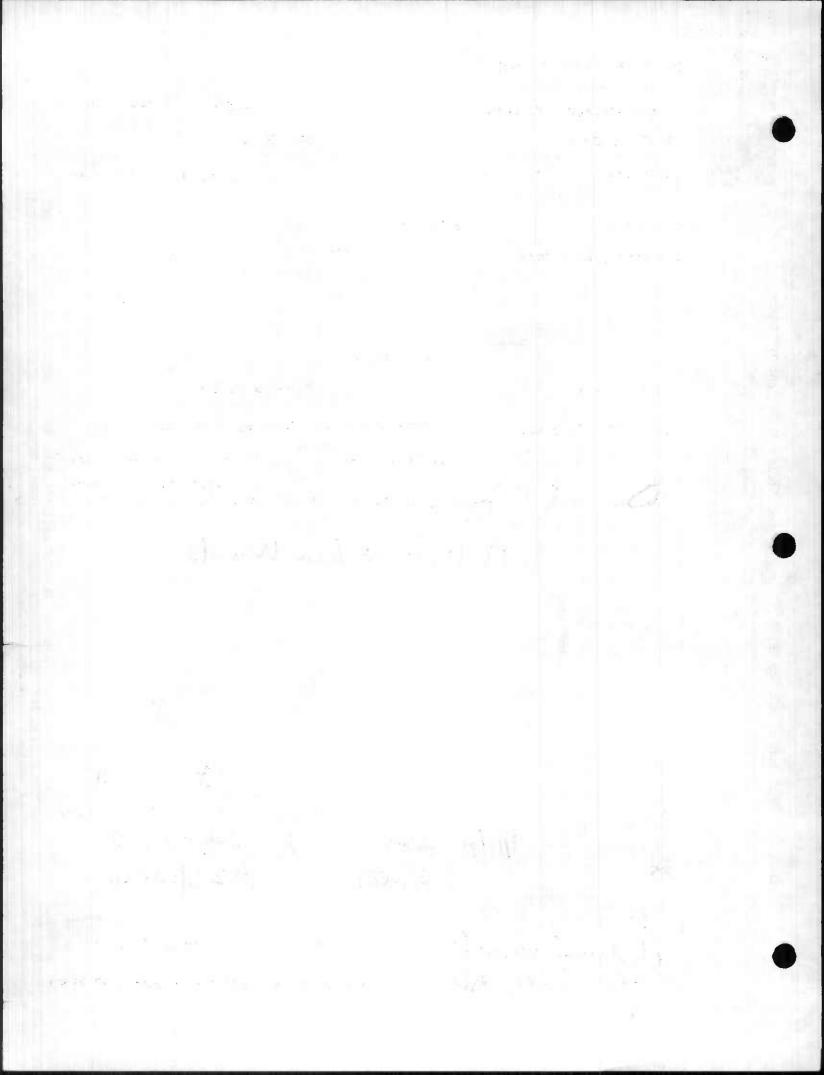
31. Date filed (Month, Dey, Year) 3 2

ON

WKE M 32, Registrer's Signeture

iss of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent'a Neme (First, Middle, Last) 3. Time of Death **Physician** 1999 10:55 AM Dorothy March /Medical 4e Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Gilchrist Hospice @ GBMC Towson Baltimore If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2√2 F Months Days Hours Min Yrs. 71 188-22-2191 27, Pennsylvania 1927 Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Director Cambria Johnstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Counfry? than "natural", or items 23s or 1111 Locust Street 15909 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No if Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11 Marifel Stafus Black, White, etc. 1 and 2 should be filed within 72 hours after of Haaith and Mental Hygiene. em 27 la marked other then "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white A 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Steve Mastovich Milka Relja 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informent's Name/Relationship (Type, Print) 7211 Sleepsoft Circle, Columbia, Md. Mark Pavich - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 3/26/99 1 XBurial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 5 Other (Specify) Johnstown, Pa. Nicholas S.O. Ch. Cem. of Funeral Sen 22. Name and Address of Facility
Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 23a. Part 1. Enter the disease, or complications/that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsef and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) Great Concer 10an Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to Completed 24e. Was an europsy completion of cause of death? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospite 1 Yes 2000 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

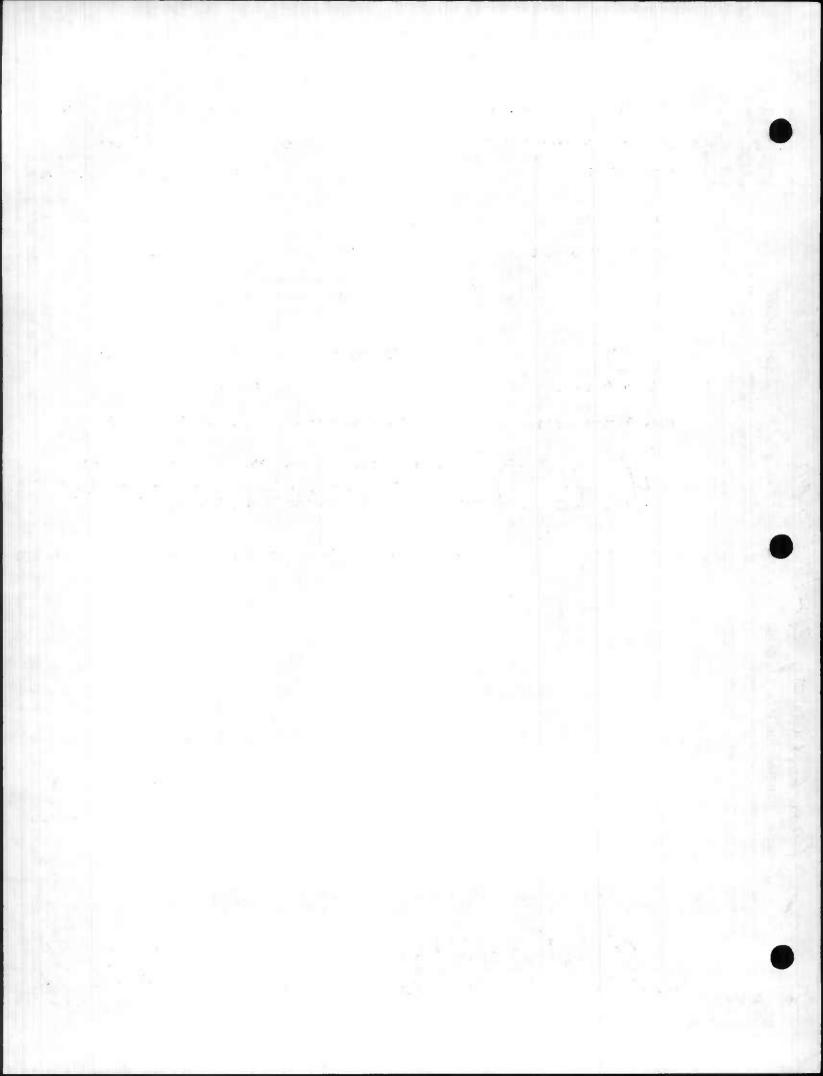
2 Medical Examíner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Certifier 25 To the To the 29b, Signgture out the obcertifier 29d. Dafe signed (Month, Day, Year) 29c. License number s of person who completed gause of death (Item 23s Type, Print) roles Str Balto, and 10 60 nc 6

Registrar **DHMH 16 Rev 6/95** 

State

31. Date filed (Month, Day, Year)

MAR 2 3 1999



## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Pilkerton Jaseph 1999 1333 March 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Bayview Medical Center Hopkins Baltimore Johns 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer | If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex Deys 1 M 2 □ F Months Hours Country) Maryland 79 216-10-5828 12-10-1919 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Dundalk 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7905 Shore Road 21222 United States 12. Wes Decedent Ever tn U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bteck, White, etc. 11. Meritel Stetus 1 Never Married 210 Married 1 Tyes 2 No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementery/Secondary (0-12) College (1-4or 5+) Steel Industry 12 years Welder 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Marie Rice Milton Pilkerton 19e. Informent's Name/Reletionship (Type, Print) 19b. Malting Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 15 Sheraton Road Randallstown, Md. 21133 Patricia A. Schultz 20e. Method of Disposition 20b. Ptace of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 03-22-99 Towson, Maryland Hilltop Service Corp. 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Duda-Ruck Buneral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23e. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate intervet Between Onset and Deeth Immediate Cause (Final diseese or condition resulting in death) Myocardial infarction hours Due to (or es e consequence of): unclear bleed aastrointestinal Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert ii. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Minknown 1 ☐ Yee 2 ☐ No artery disease, congestive 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy failure, diabetes mellitus, peripheral 1 □ Yes 2 □ No 1□ Yes Vascular disease 26. Piece of Deeth (Check only one) Other: 4 Nursting Home 5 Residence 6 Other (Specify) Hospital: 1 Appatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Netural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Coutd not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete)

physician and the bunal-transit Records, P.O. Box 68760 88 9SI 6 signed by the a cartificate Division of Vital director, this funaral After after death. Director: Aft

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• Funeral C

To the Hosp within 24 hor To the Fune completely fi

**Physician** 

/Medical

Examiner

Directo

Funeral

by

Completed

**Funeral** 

Director

7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

permit. Pagas 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hypiena. Important: If item 27 is marked other than "natural", or ital eny injury or other thatmate event, the Medical Emmina

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Certification:

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death

25. Wes case referred to medicat exeminer?
1 Yes 2 10

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 12 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signeture end title of certifier

4 Homicide

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

Cathriga 9. Sullanh U.D.
end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 30. Name

09715

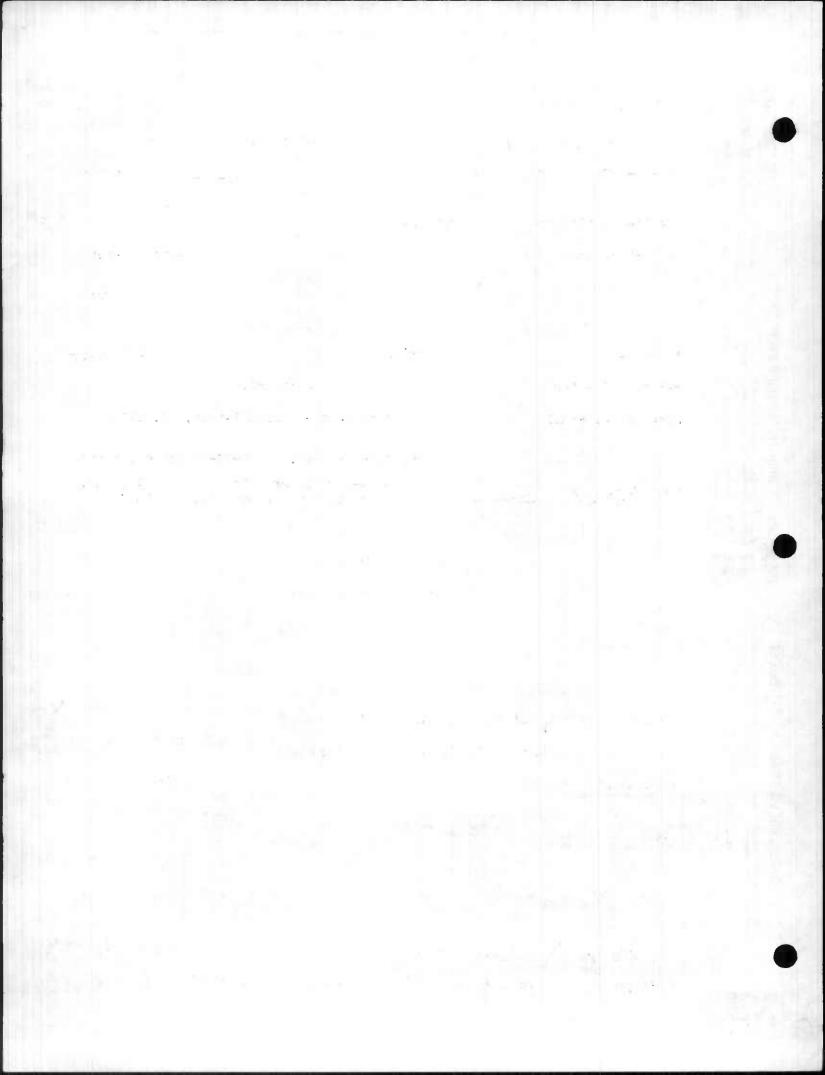
March 19, 1999

Johns Hopkins Bayview Medical Center Kathryn J. Eubank, M.D. 31. Date filed (Month, Dey, Year)

State Registrar

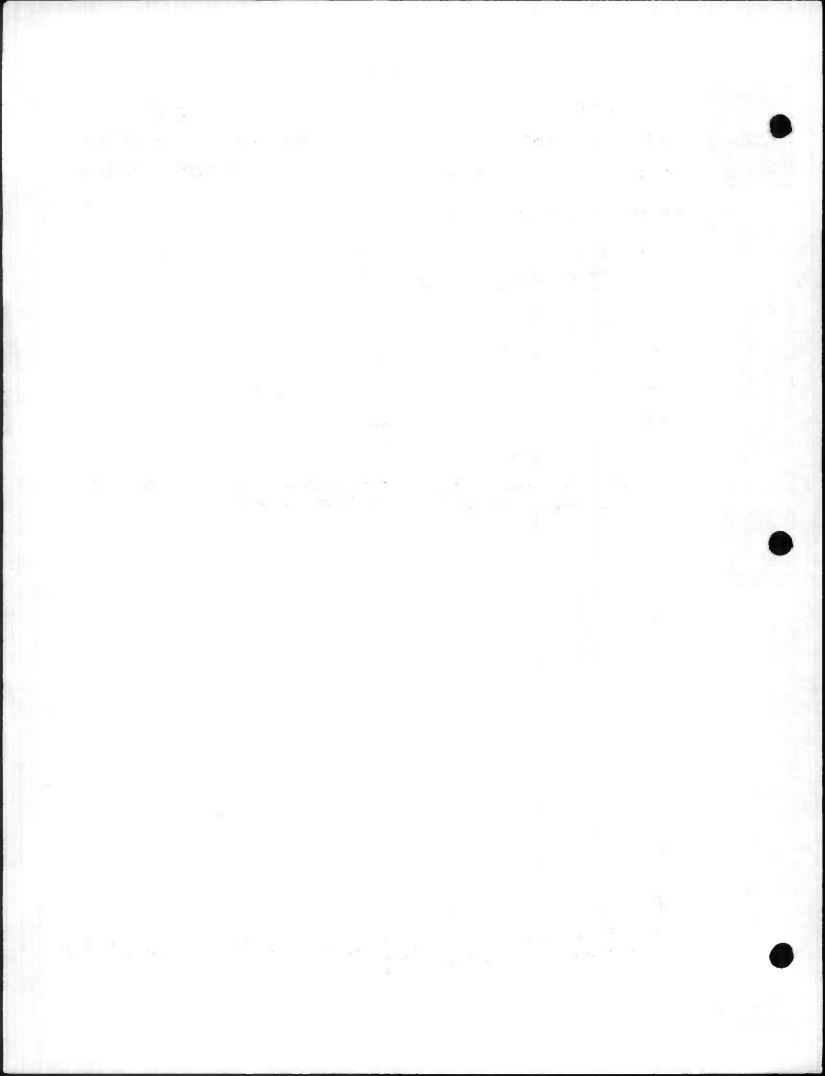
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	Director	10e. Street end Number 2413 Ruthburg R	load			10f. Zip Code 21617			10g. Citizen of Whet Country?								
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neral Dir. y filled in		29e. Cartifler 1 Certifying F	Physician: To the b	g, etc. (Specif	wiedge, deeth	n occurred et the tir	ne, dete end piece	, end due to the	wn, Stete)	anner es st	ated.						
To the Funeral Director: After th completely filled in by the funeral Medical Certification:		(theck only 2 Medical Extend of certifier	aminer: On the bes	sis of examine	tion end/or in	vestigetion, in my o	pinion, deeth occu	rred et the time,	date and pleca, 29d. Date signe	and due to	the cause(s)						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month FEB 28 1999 JOHN ROBERTSON 5:30PM 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Death SILVER SPRING MONTGOMERY CAREMATRIX OF SILVER SPRING If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 23 1918 5. Social Security Number 6. Sex 1 → M 2 □ F 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) Deys Yrs. Sept 224-24-1959 80 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yas 2 □ No Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 824 48th St., 20019 N.E. United States 12. Was Decedent Ever in U,S. Armed Forces? 1 Yas 2 □ No Raca - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Porter Supervisor Dept. Store 12th 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bruce Robertson Della Mease 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beulah Robertson / Wife 824 48th St., NE Wash., DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from Stata Ft. Lincoln Cemetery 3-9-99 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Md. 22. Name and Addrass of Facility 21. Signature of Funeral Service/License Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each ine. Immediate Ceuse (Final disease or condition rasulting In death) Recurrent 4 Monits Due to (or es e consequence of) Prostate Cancer to Lungs etastatic Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was en autopsy performed?

**Physician** /Medical Examiner

permit. Pega Department of Important: If any Injury or pace.

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

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. Pegas 1 end 2 should be filed w ment of Health and Mentel Hygier sant: If item 27 is marked other th jury or other trsumatic avant, the

death

filed within 72 hours after

21215-0020

Baltimore, Maryland

Box 68760.

P.O.

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Physician/Medical Examiner þ Completed Be

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Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last

(Check only one)

25. Was case referred to medical examiner?

Complications of Stroke

24b. Were autopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No 1 Yes

26. Placa of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: Nursing Home 5 Residenca 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. tnjury et Work? Neturel Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) and manner as stated.

Medicat Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier

29b. Signature and title of cartifier Amer to

29c. License number

29d. Date signed (Month, Day, Year)

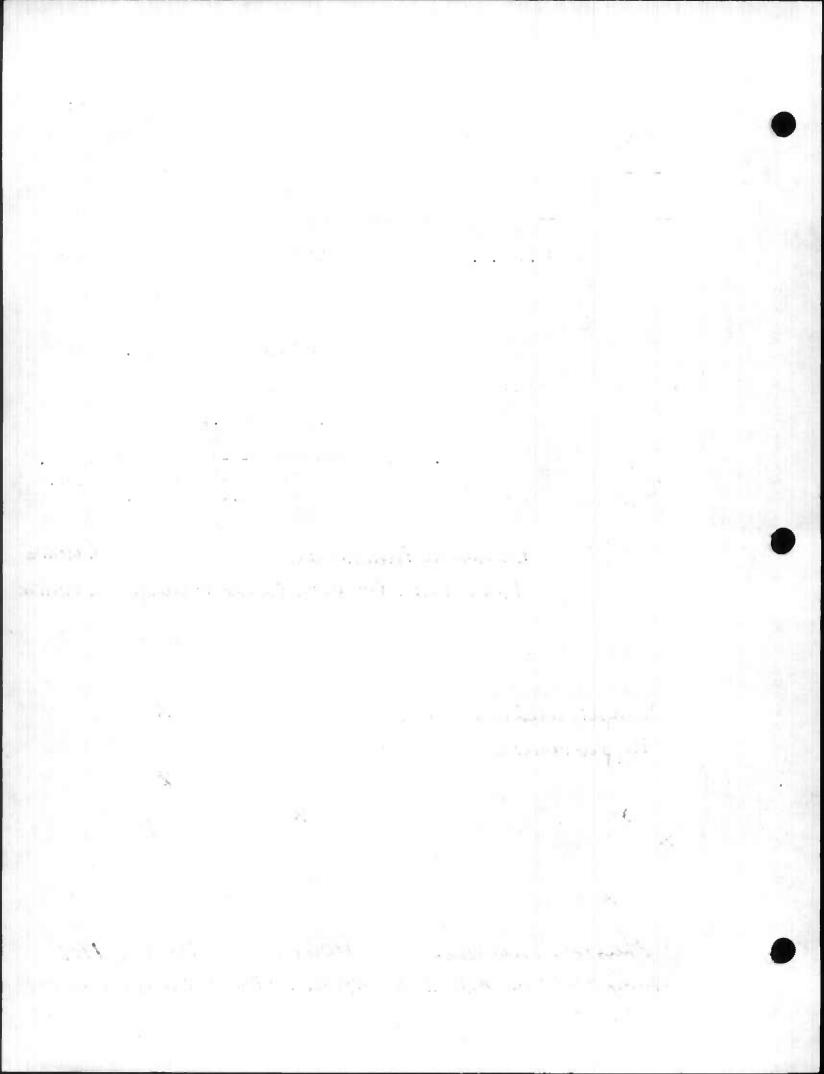
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Pitsea Dr Beltsville Md 20705-11305 Gary W. Jones M.D 31. Data filed (Month, Day, Year)

State Registrar

MAR 23 1999

32. Registrar's Signature person



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Regula Josephine 5:46 P.M 1999 MARCH 16 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street and number) Rosedale

If Under 24 Hrs. 8. Date of Birth

Winder 24 Hrs. 8. Date of Birth

Winder 24 Hrs. 8. Date of Birth

Folio 27, 1921 Examiner FRANKlin SpyARE BAITIMORE tav) If Under Hospila 9. Birthplace (Stete or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 207 F Months Deys 217-07-6673 78 Director Usual Residence of Decedent with the Maryland 10e Stete 10b County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Maryla II and Mental Hygieso. The marked other than "natural", or items 23s or 28s-1 show traumatic event, the feet than the control of the control of the feet than the contribution. 1 Yes 2 No Director Baltimore Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21236 U.S.A. 2 Bellington Court Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 5 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8th Grade Josephine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Concetta Azzaro Frank LaRosa 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Bellington Court, Baltimore, MD Michael M. Regula (husband) of Health Important: If item 27 any injury or other to 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Buriel 2 Cremation 3 Removal from State 3/19/99 Baltimore, Maryland Sacred Heart of Mary 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD lle 21236 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 1 Que Examiner Examin physiclan and s the burief-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): ettending p for use es 98 23b. Did tobacco use contributs to the causs of death? signed by the e Pert fl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? Deen s certificate has b director, paga 2 s 2 No 1 □Yes 2 □ No 1 Yes director, or Attending Physician: 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this funeral 27. Menger of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident d in by the 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours aft Funeral Di-letaly filled in Certifying Physician: To the best of my kp sindge, death occurred at the time, date and place, end due to the ceuse(s) end manner es steted.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state. 29a. Certifie edical (Check only one) within 2 29b. Signature apolitile of certific 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 17 Fontana Lane, Baltimore, MD 21237 Dr. Mohammad Rahnama,

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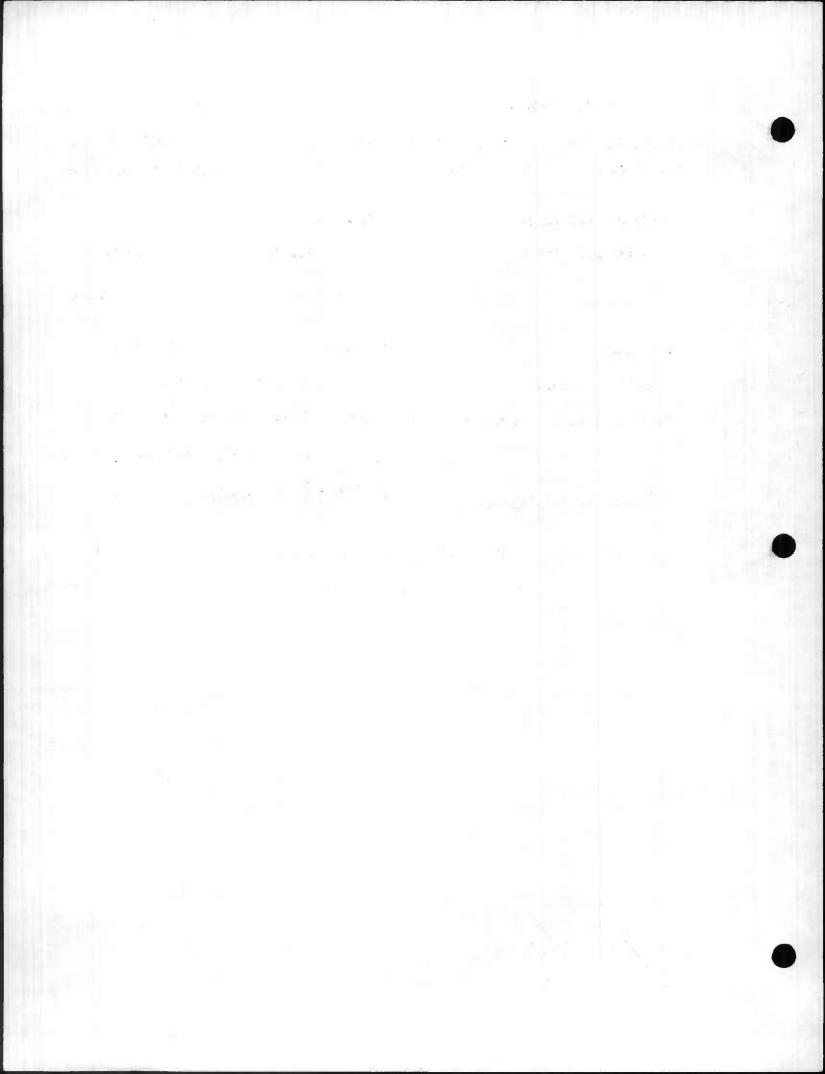
State Registrar

**DHMH 16 Rev 6/95** 

31. Dete filed (Month, Day, Year) MAR 2 3

32. Registrar's Signature

1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Marguerite Overend Ritchie 2:15 pm March 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street end number) Examiner 163 Friar Tuck Hill Sherwood Forest Anne Arundel if Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthpiece (Stete or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1□M 2₩F Vrs Oct. 14,1910 326-32-4281 88 Director Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or flems 23a or 28a-f shot traumatic event, the Medical Examiner must be notified as MD 1 Yes 25 No Anne Arundel Sherwood Forest Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 163 Friar Tuck Hill 21405 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritai Status Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: White py 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12 Bookstore 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Clarence E. Overend Marquerite Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Margo Tessitore (Daughter) 128 Mountain Avenue, Warren, NJ 07059 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 03/22 Baltimore, MD 21. Signature of Funeral Service Lic 22. Name end Address of Facility Hardesty Funeral Home, P.A. alm 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. Approximete Interval Between Onset and Death **Physician** / Stadder Carcumane Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Due to (or es e consequence of) ettending physician end for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest USB as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contributa to the causa of death? the 3 Probably 4 Unknown signed by 1 ☐ Yes 2 ☐ No g 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy Deen cartificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 10 1 Yes 9 Sesidenca 8 □Other (Specify) 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of tnjury 28d. Describe how injury occurred 28c. tnjury at Work? Certification: Ather 1-Datural 2 Accident 5 Pending Investigation 1 TYes 2 TNo Director: 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide edicai Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only within 2 29b. Signeture and title of certifier 29d. Date signed (Month, Dey, Year)

Division of Vital Records, P.O. Box 68760 24 hours a å

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death 1

Baltimore, Maryland 21215-0020

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The law requires that the death

Attending

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State Registrar

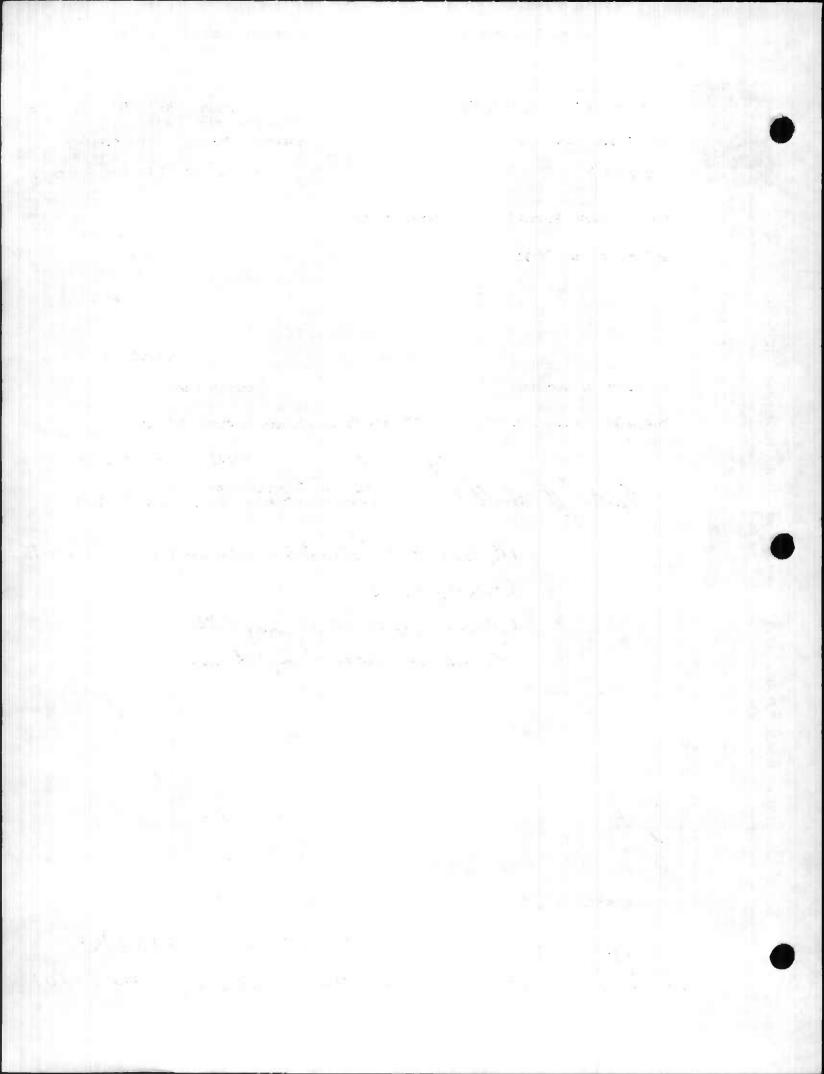
DHMH 16 Rev 6/95

31. Date filed (Month, Day, Yeer) 23

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ANDREW CORDON MD 2003 Medical Plusey Ste 100 Anapoli Md 21401



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 20 1999 4:20 AM Whitfield Shifflett 4b. City, Town, or Location of Death 4e Facility Neme (If not Institution, give street and number) 4c. County of Death N/A 1623 McHenry Street Baltimore 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1X M 2 ☐ F Yrs. 172-12-2109 Sept. 23 1905 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Y Yes 2 No Maryland N/A Baltimore 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? 1623 McHenry Street United States 14. Race - American Indian, Black, White, etc. 21223 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Merital Stetus 1 Yes 2 No 1 Never Married Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Yeer or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Southern 5Th. Grade States Laborer 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Whitfield Shifflett Cora Commer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1623 McHenry Street Baltimore, Maryland 21223 Mabel Shifflett/Wife 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 Cremetion 3 Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) Cedar Hill Cemetery D3/23/99 Brooklyn Park, Md. 21. Signature of Runeral Service Licensee 22. Name end Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 23e. Part1. Enter the disease, or compressions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only on cause on each line. 21075 Approximete Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in deeth) ARRITUMIA Due to (or es e consequence of): FIBRIUTION Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last Due to (or es a consequence of): PANCOPPRIA Due to (or es a consequence of): MYLODYSPLASIA Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Nutralavia, Anamia 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? SGLOWSDRY 1 Yes 2 PNo 1 Yes 2 No 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Panding investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

The law requires that the death certificate be executed Box 68760 USB 98 funeral director,

Examine Physician/Medical

**Physician** 

/Medical

Examiner

Funeral Director

Completed by

Be

**Funeral** 

Director

show

filed within 72 hours after

I Hygiene.

i. Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: if item 27 is marked other to jury or other traumatic event, to

Department of Important: If any Injury or page.

**Physician** 

/Medical

Examiner

21215-0020

Baltimore, Maryland

of Vital Records, P.O. Medical Certification: To Be Completed by 25. Was case referred to medical exeminer? 1 Yes 2 No 27. Menner of Death Division or Attending 1 Naturel within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) \$ 29b. Signature and

MMM DARWIN, MD

29c. License number

29d. Date signed (Month, Day, Year)

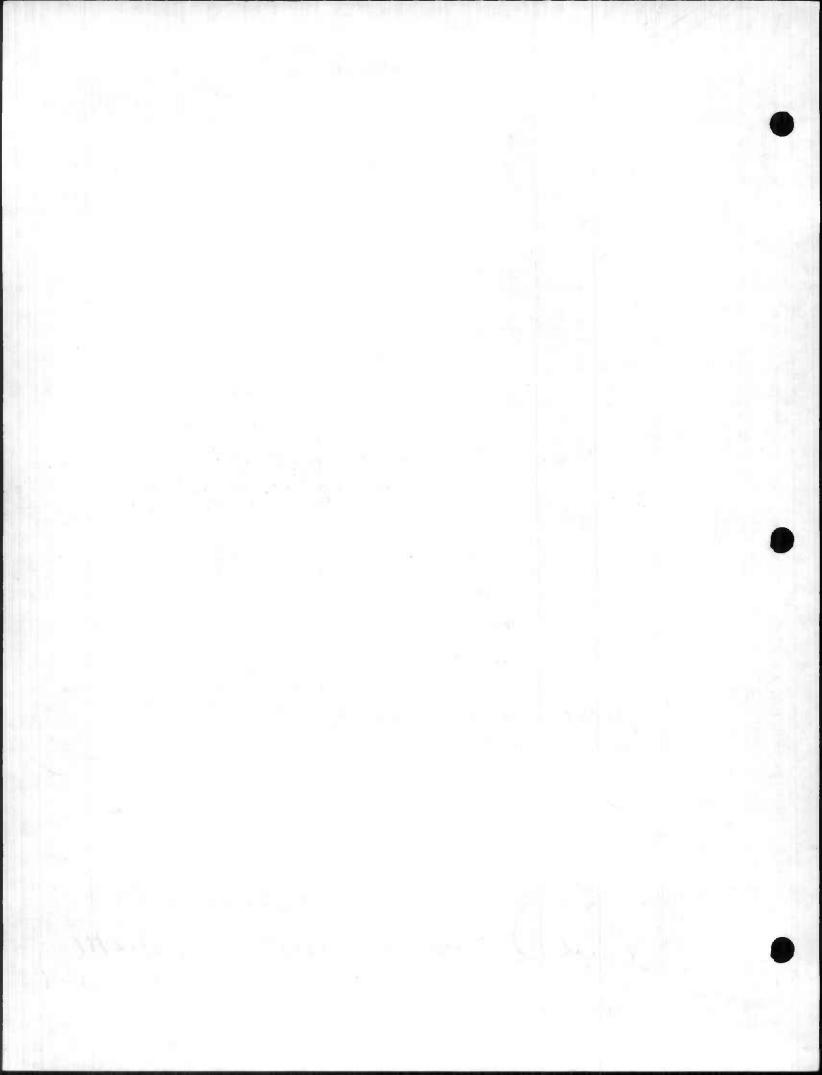
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

225-6REGWE ST umms

31. Dete filed (Month, Day, Year) State Registrar

MAR 2 3 1999

32. Registrer's Signeture



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death MARCH 20 Day 1999 Year **Physician** DR. MAX SOLOW 3pm /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 725 MT. WILSON LANE # 530 BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 8. Date of Birth NOVIII 20v. 19916 9. Birthplace (State or Foreign 51598-07-5007 **Funeral** 82 Yrs. PENNSYLVANIA Director Usual Rasidance of Decedant 10d. Insida City Limits 10c. City, Town or Location BALTIMORE 10a. Sigle 10b. County BALTIMORE ahon must be notified at 1 Yas 2 No Director 28a-1 725 MT. WILSON LANE # 530 101 Zip Code 21208 10g. Citizen of What Country? "natural", or flems 23s or Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, Whita, atc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? 17 Yas 2 No WW II 1 Nevar Married 20 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: WHITE À 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elamentary/Secondary (0-12) Collega (154 5+) PHYSICIST U.S. NAVY Department of Health and Mental High Important: If New 27 is marked other any Injury or other trauments 17. Fethar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be CELIA ARANOW ISRAEL SOLOW 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 725 MT. WILSON LANE #530 BALTIMORE MD 21208 RUTH SOLOW/ WIFE 20a. Method of Disposition

14 Buriai 2 ☐ Cremation 3 ☐ Ramovai from Stata 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, Stata cematary, crematory or other place)
ARLINGTON CEMETERY—CHIZUK 3/22/99 BALTIMORE MD. 4 Donation 5 Othar (Specify) AMUNO CONGREGATION 21. Signature of Soperal Service Lice 22. Nama and Addrass of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or fleen failure. List only one cause on each line. **Physician** tmmediata Causa (Final disaase or condition rasulting in death) (ardispulmenay) /Medical **Examiner** Examiner Dronars GVEN certificate be executed Sequantially list conditiona, if any, laading to immediata causa. Enter Underlying Cause (Diseasa or injury that initiated events resulting In death) Last Dua to (or as a consequence of): and Concestire attending physician for use as the buria heart P.O. Box 68760 Physician/Medical Die lo (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the causs of death? signed by the 05 structine pulmonary 1 Yss 2 40 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy peed completion of ceusa of death? cate has 1 Yas 2 PNo 1 Yas 2 No this certificate Division of Vital or Attending Physician: after death. Director: After this certifica director. Be 25. Was casa rafarred to medical 26. Placa of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 Yas 2 No After this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) To the Hospital or Av within 24 hours after To the Funeral Direc completely filled in b 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to tha cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axaminetion and/or invastigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and mannar statad. 29a. Certifiar 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30339 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) 4000 Old Court Rd; Ballimore; DA WISTER, ND Milan

DHMH 16 Rev 6/95

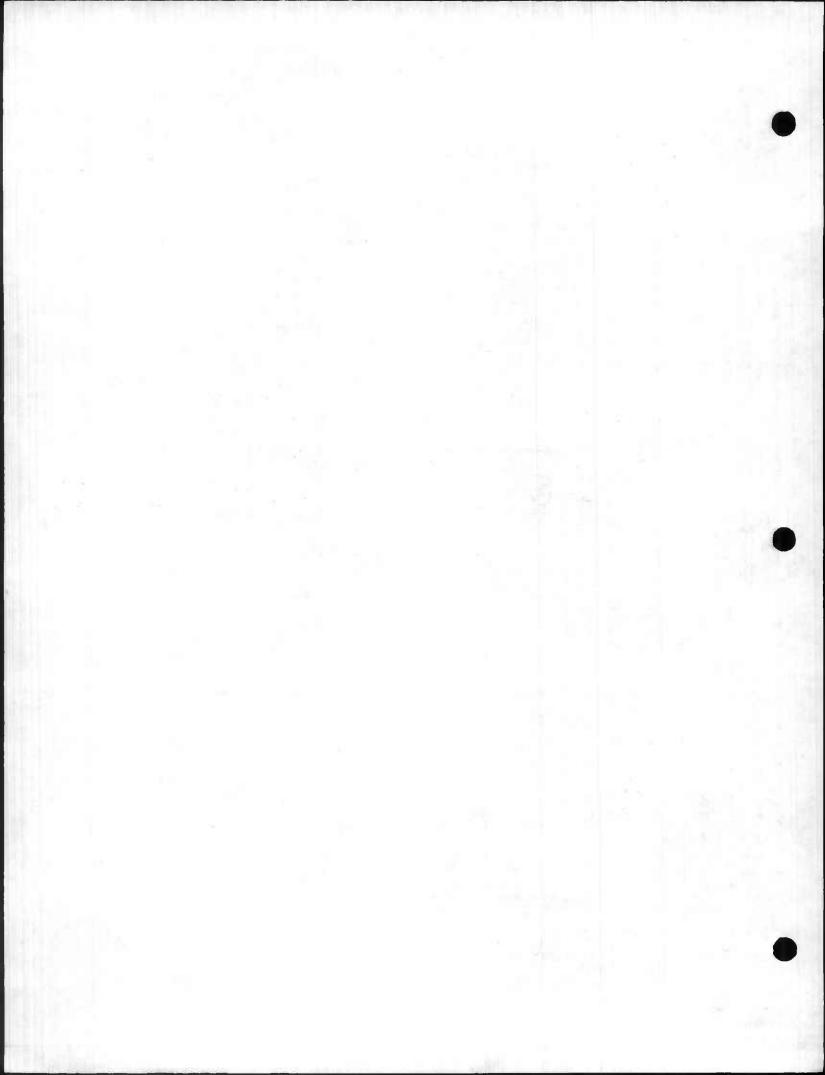
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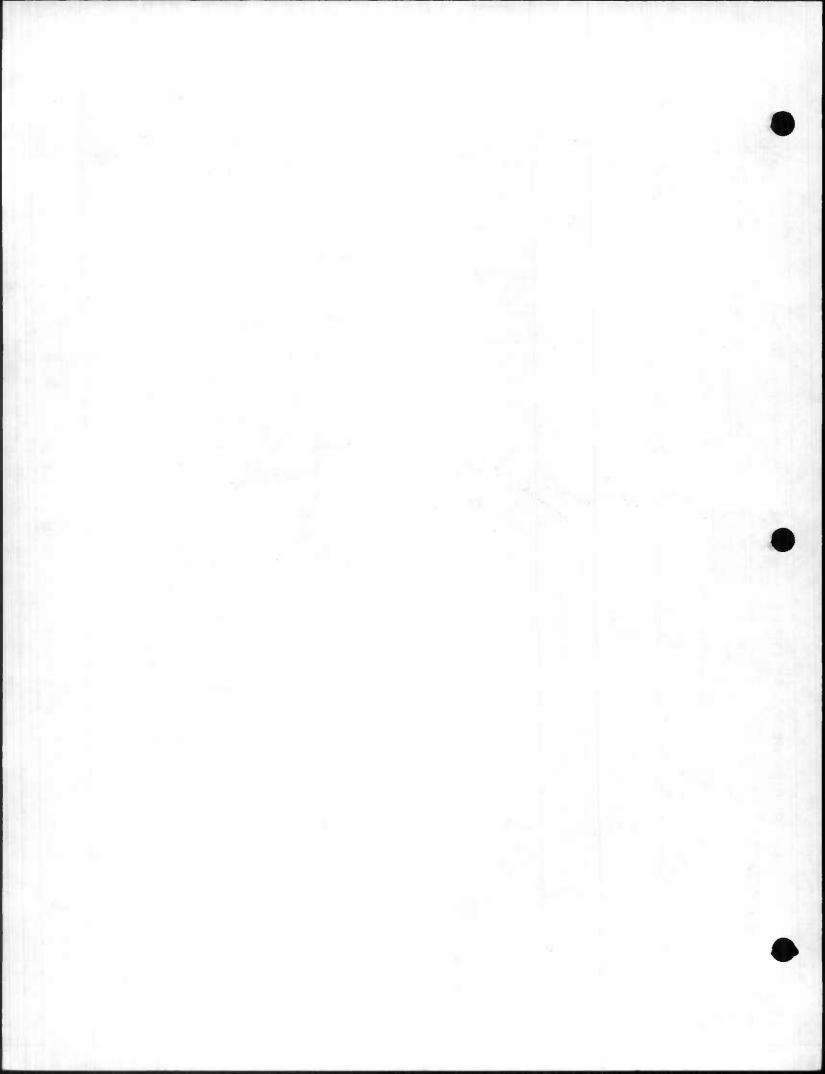
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State of Maryland / Department of Health and Mental Hygiene 0 01, 97

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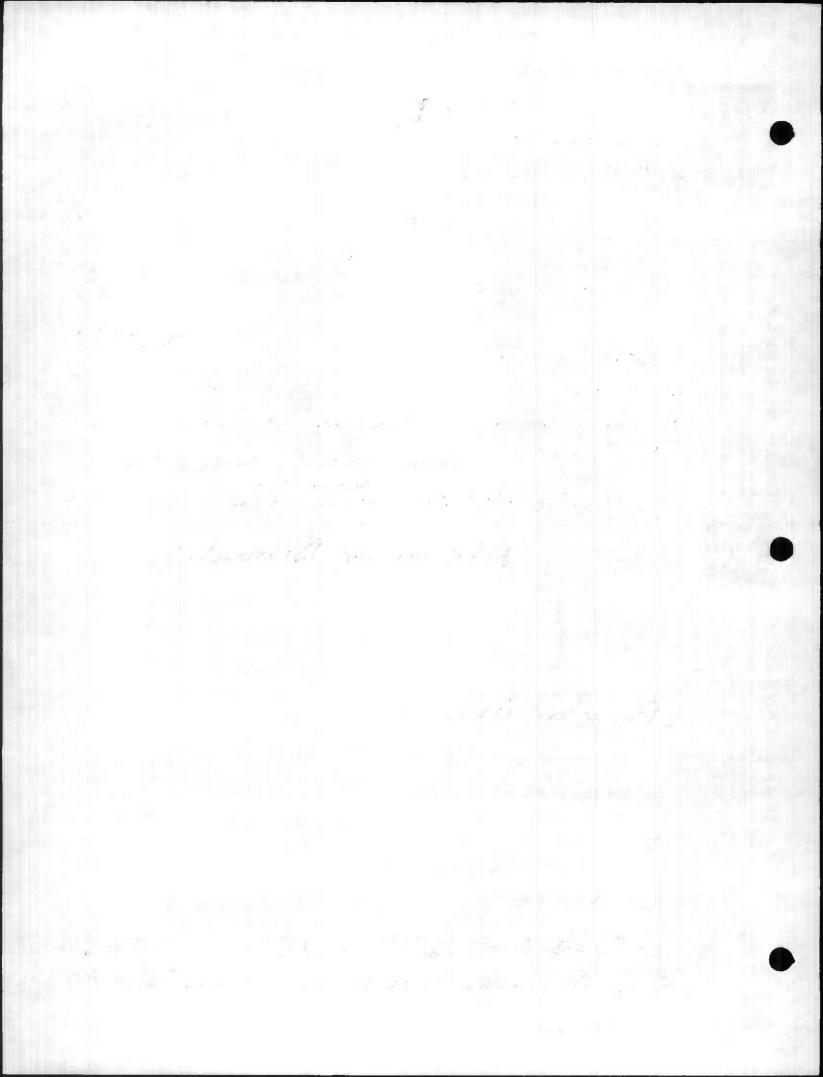


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 26 per M.D G-769 3/23/99 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Lillian Scott 11:19 a.m 1999 16 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not Institution, give street and number) Examiner Bayview Medical Center Baltimore N/A If Under 1 Year if Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 3 - 17-5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1□ M 2□F 212-24-8340 78 Yrs. Va Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits r 28a-f show inotified at 1X Was 2 □ No Director Md N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with "netural", or items 23s or adviced Examiner must be a 1310 Luzerne Avenue 21213 USA permit. Peges 1 and 2 should be filled within 72 hours after death v. Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a and Injury or other traumatic event, the Medical Examiner mental page. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Mamied 2 Married **Black** 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 à 3 Widowed 4 Divorced Completed 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Baltimore City Collage (1-4or 5+) N/A Elementary/Secondary (0-12) Cafeteria Assistant 7th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumame) York Eggleston Temple Walton 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) Mary Lowery - Daughter 115 N. Broadway Apt 1 Baltimore, Md 21231 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 □ Donetion 5 □ Othar (Specify) Baltimore 3-22-99 Cemetery Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Avenue Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsef and Death Physician Dementia /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequanca of): Examin physician end the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Causa (Diseasa or Injury that initiated events resulting in death) Lesf Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) for use es t signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown by been si 24a. Was an autopsy performed? 24b. Wera autopsy findings available prior lo Completed completion of ceuse of death? nis certificate has b 1 Yes 2 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospifal: To 1 Yas 25 No Other: 4th Nurstng Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. fnjury at Work? 5 Pending investigation 1 Naturai 1 Yas 2 No death. 2 Accidant after death Director: in 24 hour.
the Funeral Direction of the 6 Could not be datermined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signafure and 29c. License number Ziciz Mirzu NINS 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) 1113 a MB, 3007 E No New Parkway, Butte mp 21214 31. Dete filed (Month, Day, Year) 32. Regisfrar's Signature

State Registrar

MAR 2 3 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 20b per F.H G-769 3/23/99 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2:30 AM MAR Verlyne Shaw 20 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore NA 5. Social Security Number Frederick Avenue If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) Days Hours 1 M 200/F 62 Months 216-34-5994 -1936 Ma Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yas 2 No Director Ma 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? U.S.A 21229 redenck Avenue Funeral 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Married Blade 1 Yes 2 100 Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry UNIZ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 41 grade Janitor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be John Kobinson er 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ierald Thomas-Son 3603 ottage Avenue Baltimore Md 20e. Method of Disposition

1 Disposition

3 Removal from State

Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 3-25-99 atonsville Ma 1etro Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee arch F. H. West Avenue 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Daltimore Md 21215 Approximata Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other afgnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No Be 25. Was cese referred to medicei examiner? 26. Piace of Death (Check only one) 1□ Yes 2☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) D18587

State Registrar **DHMH 16 Rev 6/95** 

**Funeral** 

Director

28a-f show

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permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene, introcramt: if flem 27 is marked other than "natural", or flem any injury or other traumatic event, tra Medical and

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To the Hosp within 24 hos To the Fune completaly fi

that the death certificate be executed

Box 68760,

Division of Vital Records.

Attanding Physician: The law requires

Baltimore, Maryland 21215-0020

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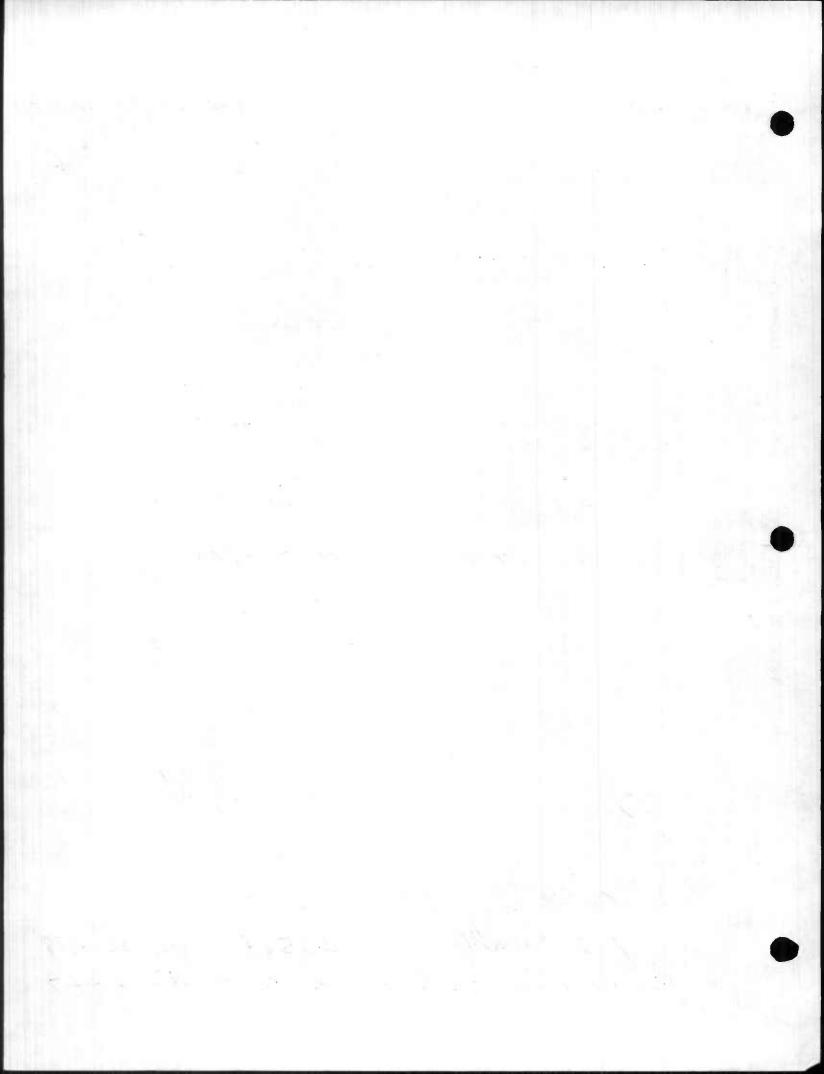
32. Registrar's Signature

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30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Mary S. Sydekes 1999 March 19 7:20 P.M. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva streat and number) Examiner Rock Glen Nursing & Rehabilitation Center N/A Baltimore If Under 1 Yaar Months Days If Under 24 Hrs 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** 1□ M 2 F Hours 73 218 22 6628 Jan. 22, 1926 Director Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Modical Examples must be notified at 1 X Yes 2 □ No Directo Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 U.S. 2226 Wilkens Avenue Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yas 2 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home 3rd 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Mary Petrauskus Anthony Sydekes 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) 2226 Wilkens Avenue Baltimore, Maryland 21223 Toni Vitkauskas / cousin other 1 20b. Place of Disposition (Nema of cemetery, cremetory or othar place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department Important: It any Injury e 3/24/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 romerousk in lications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, if one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Liver Failure Days disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Months Metastatic Cancer Breast physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): USB 0 e dateched i Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Gastrointestinal Bleeding by 24b. Were autopsy findings evallable prior to completion of ceuse of death? 24e. Was an autopsy Completed paga 2 1 ☐ Yes 2X No 1 Tyes 2 No director 25. Was cese referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4XX Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funerel 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 ☐ Homicide complataly filled ↑ Certifying Physician: To the best of my knowledge, death occurred at the fime, date end place, end due to the ceuse(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifier 29c. Licansa number

State Registrar

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Hospital or Attanding Physician: '24 hours after death.' Funeral Director: After this certifica

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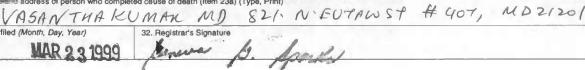
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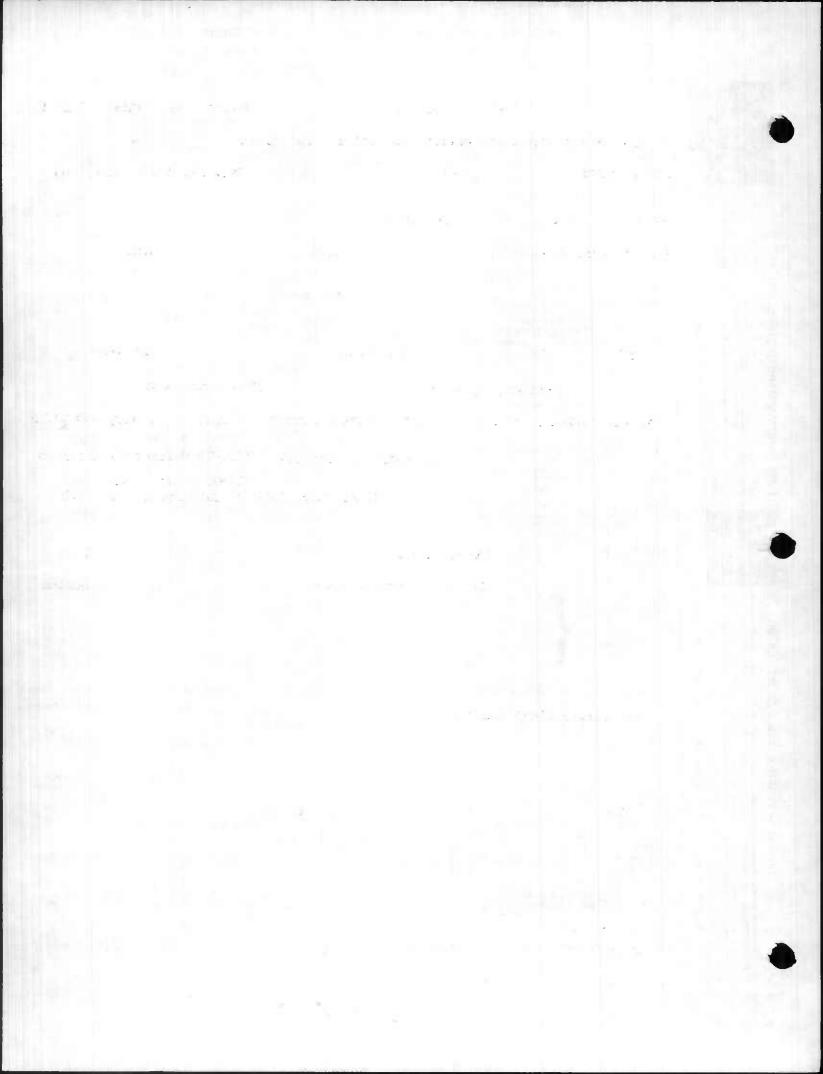
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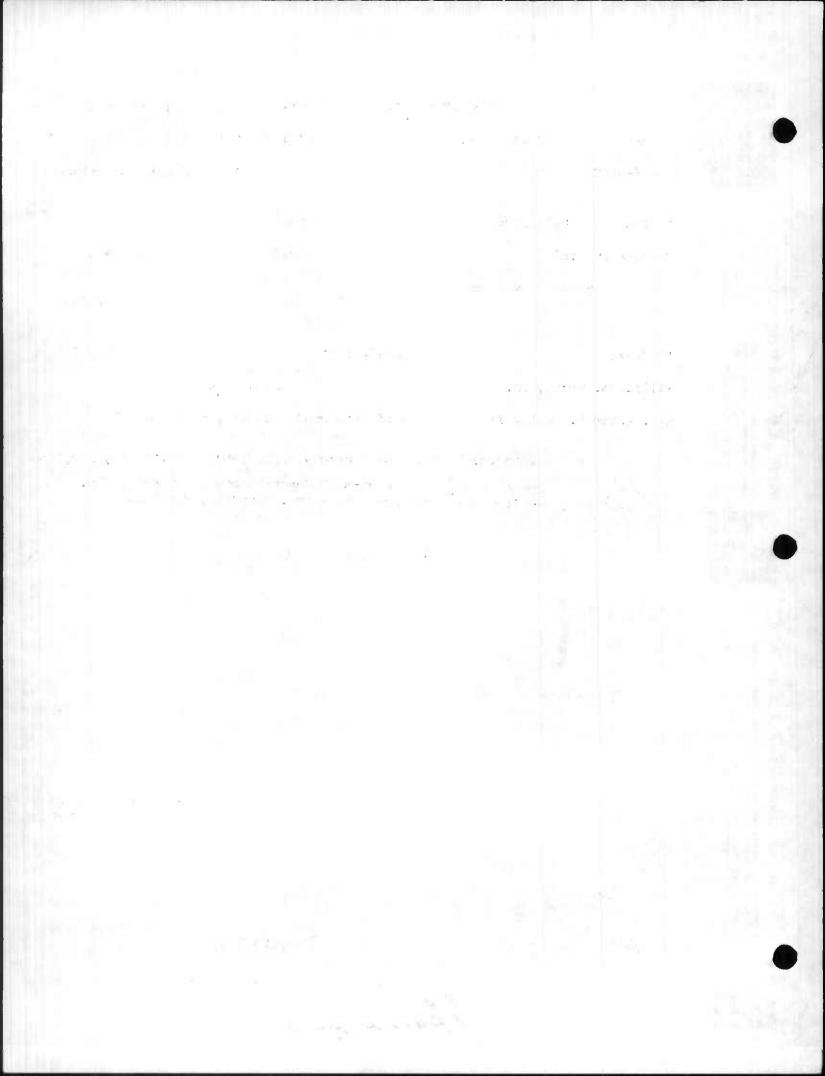
opanthalcuma address of person who completed ceuse of death (Item 23a) (Type, Print)





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedant's Nama (First, Middle, Last) **Physician** 20 William Winfield Scott, Jr. MARCH · /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner Baltimore City N/A Stella Maris @ Mercy Hospital If Undar 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) June 8,1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiaca (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F Yrs. 174-24-4137 68 Pennsylvania Director Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be nothled as 1 Yes 2 No Director Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 94 Kinship Road 21222 United States Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, 11 Marital Status 12. Was Decedant Evar in U,S. Armed Forces? Black, White, etc. should be filed within 72 hours after on Mentel Hygiena. 1 ☐ Naver Married 2 Married 1 X Yas 2 □ No 1 Yas 2 No Specify: Specify þ White 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highast grada complated) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Steel Industry Millwright 12 Years 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be facent of Health end Mentel Int: If item 27 is marked of Emma Turner William W. Scott, Sr. 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Depertment of Health e Important: If item 27 is any injury or other tra-94 Kinship Road Dundalk, Maryland Mrs. Betty L. Scott/Wife altimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 3/15/1999 Baltimore, Maryland Oak Lawn Cemetery 4 Donation Stromer (Specify) Entombment ral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part. Enter the distase, or complications that caused the death. Do not enter the mode of dyling, such as cardiac or respiratory arrest, shock, or heart light e. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** Punceatic Curur /Medical Immadiata Causa (Final north disaasa or condition resulting in death) Examiner Examiner requires that the death certificate be axecuted physician and s the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting In death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to complation of causa of deeth? Completed 24a. Was an autopsy 1 Yas 2 50 1 Yas 2 No certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Plece of Death (Check only one) StE //A MARIS AT MERCY Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify)# 05 picE 1 Inpatient 2 ER/Outpatienf 3 DOA this 28d. Describe how Injury occurred 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After Neturel 5 Pending death. 1 Yes 2 No 2 Accident investigetion 3 Suicide 6 Could not be determined 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, sfreef, factory, office building, etc. (Specify) 4 Homicide 24 hours Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier To the To the To the 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signature and title of ceptifiar 40854 49 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Paul Pl Balding Reschon 301 31. Date filed (Month, Day, Year) 32. Registrar's Signal State Registrar DHMH 16 Rev 6/95



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth 1999 MARCH 20 5:25 am CHARLES F. SCHULTZ 4b. City, Town, or Location of Deeth 4c, County of Death 4a Facility Name (If not Institution, give street and number) TOWSON If Under 24 Hrs. GILCHREST HOSPICE CENTER BALTIMORE If Under 1 Year 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 XM 2□ F Months Days Hours Min. Yrs. 63 212 30 8480 MARYLAND Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE ROSEDALE 10f. Zip Code 10e. Street and Number 10a. Citizen of Whet Country? 8001 HAAS LANE 21237 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Merried 1□ Yes 20XNo Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Spacify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elemantary/Secondary (0-12) 8 MACHINIST DEPT STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) CHARLES S. SCHULTZ CATHERINE S. TRECANNELLI 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) JEAN SCHULTZ / WIFE 8001 HAAS LANE BALTIMORE, MD 21237 20b. Placa of Disposition (Name of cometery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 3/23/99 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or raspiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CAncer of the Bladder Immediate Ceuse (Final disease or condition resulting in death) bery Sequentially list conditions, if any, leading to Immediate causa. Entar Undarlying Cause (Disease or Injury that initiated events Due to (or es a consequence of): Due to (or as a consequence of): resulting in death) Lest Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA tospice 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Time of 1 Netural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be detarmined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of fnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

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/Medical

**Examiner** 

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**Funeral** 

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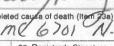
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29a, Certifier

(Check only one)

29b. Signature and title of

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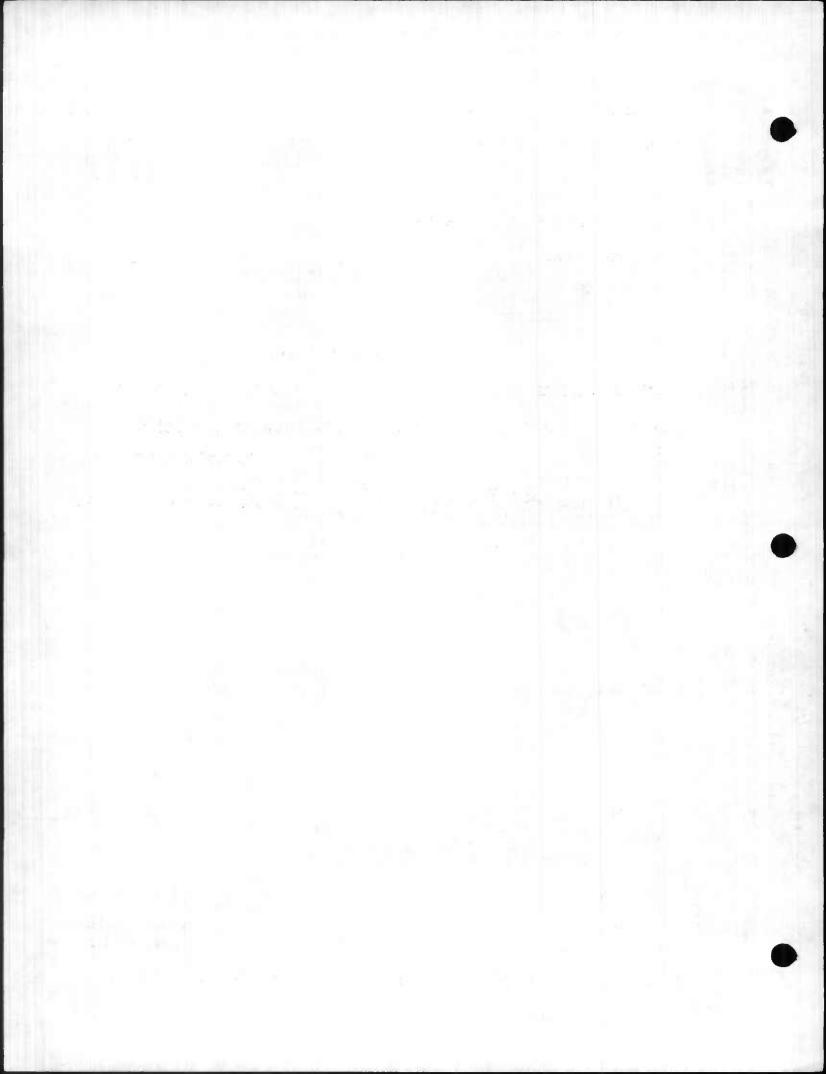
15 Certifying Physicfan: To the best of my knowledga, daath occurred et tha tima, data and place, end dua to tha cause(s) and menner as stated.
20 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) March 20, 1999

30. Name end eddress of person who completed cause of death (Item 33a) (Type, Print) 6BMC 10

St. Balto, md ZIZOX Charles

31. Date filed (Month, Day, Year)

32. Registrar's Signature



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month 8:50 PM Mildred Adelaide Smith 1999 March 11 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death N/A Good Samaritan Nursing Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1□M 2\ F Months Days Hours Min. 95 Yrs. 181-20-7284 May 31, 1903 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. Counts 10d. Inside City Limits 1 Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3108 Abell Avenue 21218 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indien Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced White 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Louis Anthony Williams Marie Schiavone 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie F. Smith / Daughter 3108 Abell Avenue Baltimore, MD 20b. Piaca of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/15/99 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery Baltimore, Maryland 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Home, Inc. Even! Ettle 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate triterval Between Onset and Death immediete Cause (Final diseese or condition resulting in death) Due to (or as a consequenca of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequenca of): Due to (or es e consequenca of): 23b. Did tobacco use contribute to the causs of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 □ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. i or Attending Physician: efter death.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Directo

Funeral

P

Completed

7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Mouleal Examinating that be notified as

permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiena. Introctant: If item 27 is marked other than "natural", or items 23a and injury or other traumatic event, the Mental Exercises 23a page.

**Physician** /Medical

Examiner

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29a. Certifier

4 Homicide

3altimore, Maryland 21215-0020

the Marylend

To the Hospital within 24 hours e completaly

State Registrar

6 Could not be determined

pudue

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and manner as steled.

2 Madicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and menner stated. 29c. License number D 30661

29d. Date signed (Month, Day, Year) March 19, 1999

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

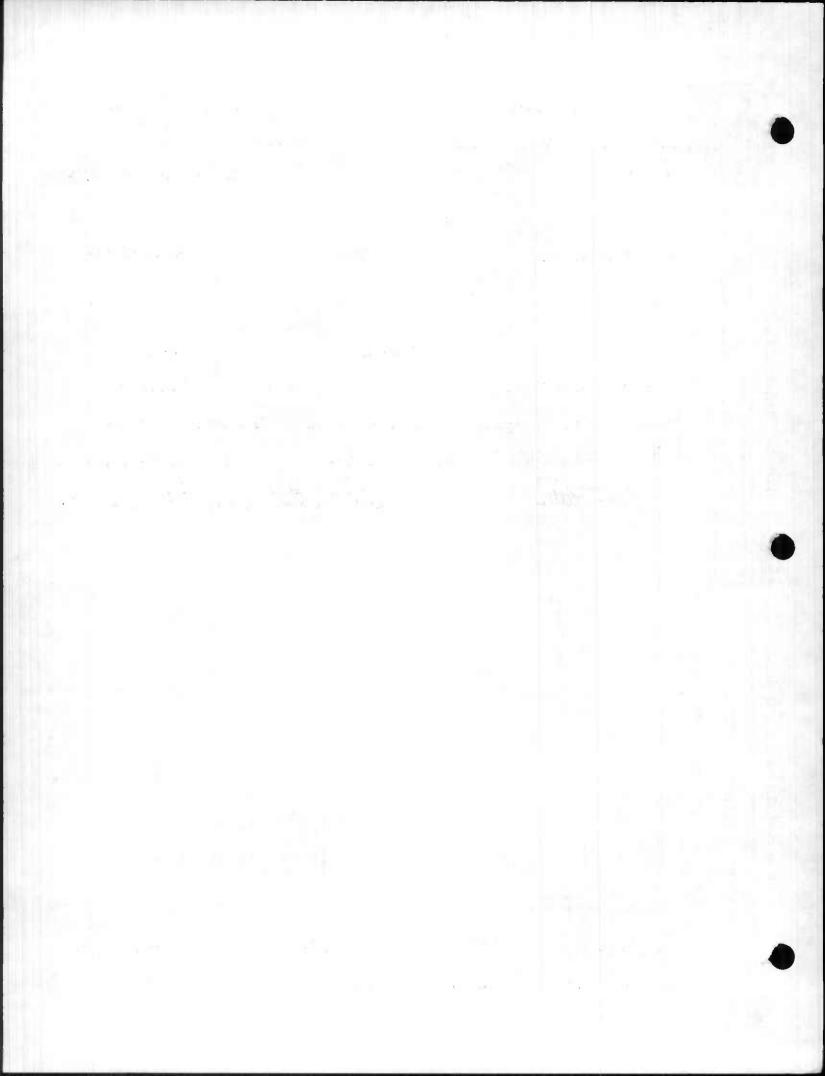
Sireesh Tripuraneni, M.D. 5601 Loch Raven Blvd. Baltimore, MD 21218

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MAR 23 1999

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death Reg. No 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day Year **ESTHER** SHANKLIN 03 99 16 5:10 PM 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) Birthplace (Stata or Foreign Country) Months Days Hours 1 M 2 X F 220-34-5069 Aug. 28, 1905 Baltimore, Maryland Usual Rasidanca of Decedan 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Baltimore Fork 10e. Streat and Number 10f. Zip Code 10g. Citizen of What Country? 2613 10 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No M Yas, Giva 14. Raca - Amarican Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Black, Whita, atc. 1 Navar Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced Yaar or Datas: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind ot Businass/Industry Kingsville Elementery/Secondary (0-12) Collega (1-4or 5+) 8 yrs. Day Lady Elementary School n/a 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Meiden Sumama) George R. Pearce Esther Anna Smith 19a. Intormant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 9906 Marilynn Road Helen S. Smith (Daughter) Perry Hall, Maryland 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1X Burlal 2 Cramation 3 Removal from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) Fork Methodist Church Cemetery 3/20/99 Fork, Maryland 21051 21. Signature of Euneral Service Lice 22. Nama and Address of Facility E.F.Lassahn Funeral Home 23a. Part1. Enter the disease, or confplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximeta Approximeta Interval Batwaan Onsat and Death Immediata Causa (Final disaasa or conditior rasulting in daath) Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Due to (or an consequence of): Dua to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 2) No 1 Yaa 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 ☐ Yas 2 ☐ No 25. Was casa ratarred to medical examinar? 26. Place of Deeth (Check only one) 1 Yas 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Deta of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 ☐ Pending 1 Yes 2 No invastigation 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760 Division of Vital Records, P.O. **Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f ahov

or items 23a or

"natural".

Hygiene. then

permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If item 27 Is marked other tany Injury or other traumatic aware.

**Physician** /Medical

Examiner

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Certification:

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traumatic event, the Medical Examiner must be notified at

the Maryland

72 hours efter

Baltimore, Maryland 21215-0020

or Attending Physician: this After after death. Director: 24 hours a Hospital within 2 To the

State Registrar

29b. Signatura and um of ceptilia

Day, Year)

MAR 2 3 1999

29c. License numbe

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mennar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

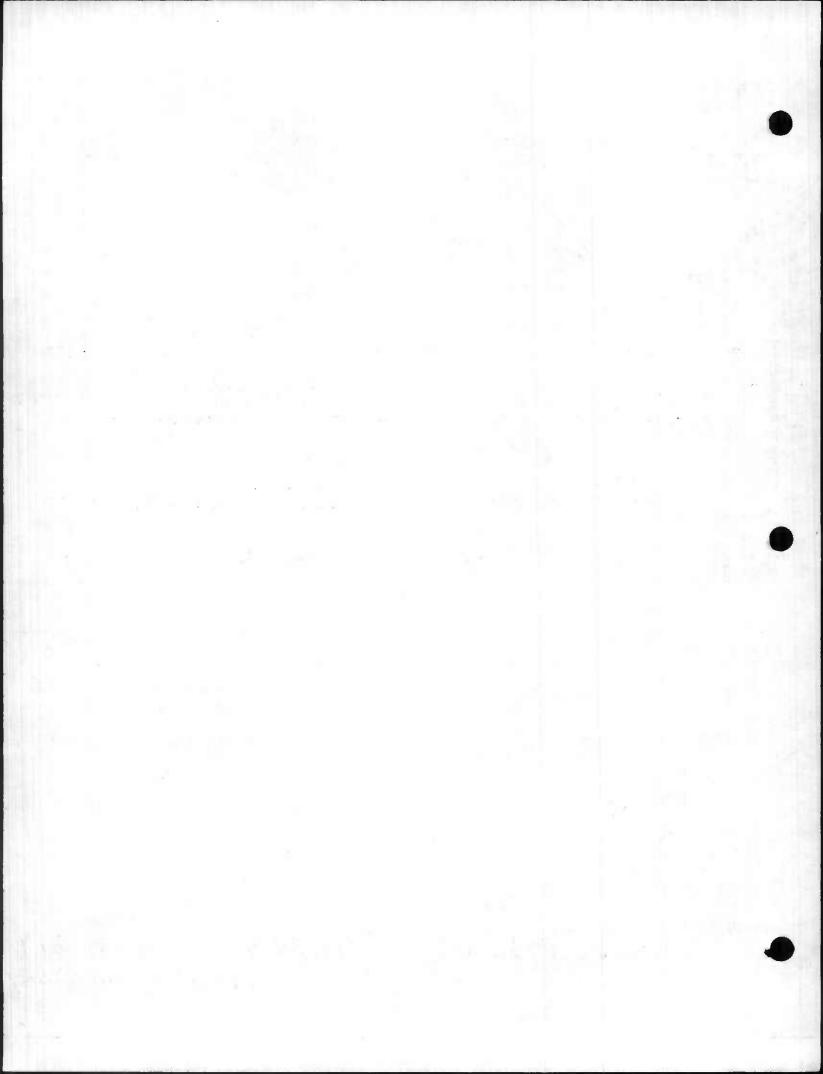
29d. Data signed (Month, Day, Year)

drass of person who completed cause of death (Item 23a) (Type, Print)

for a Rd fallston MD 2104

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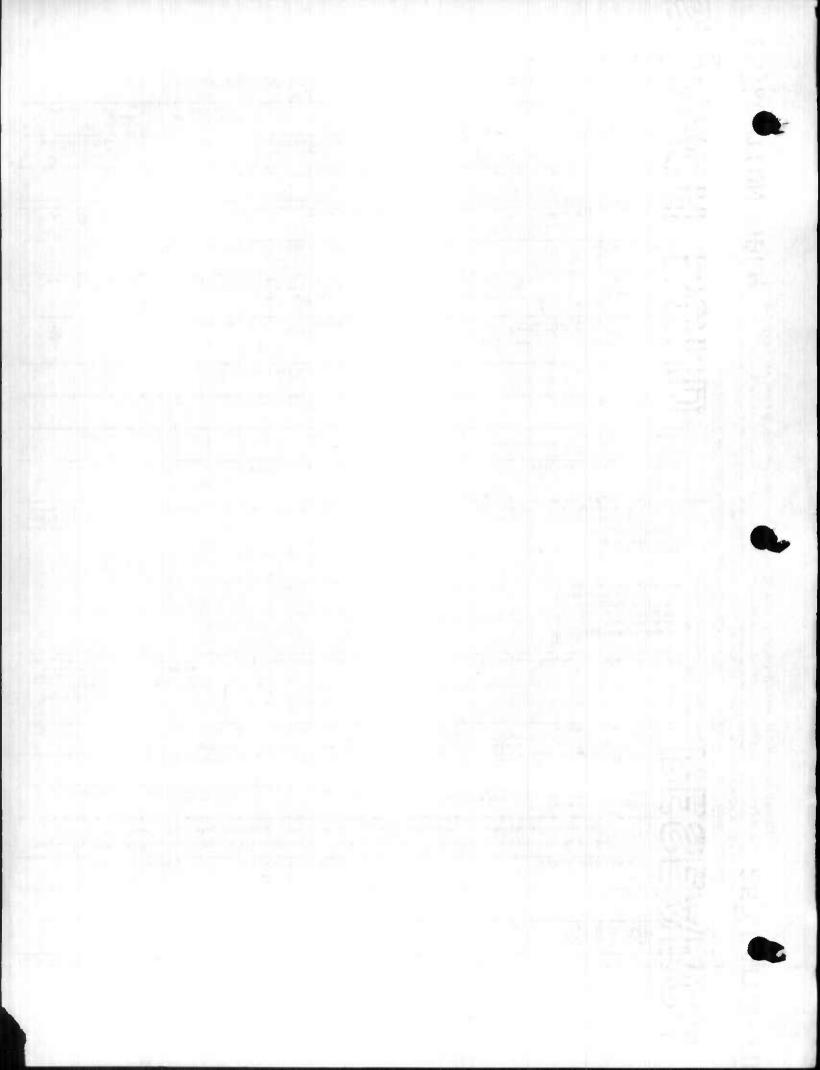
32. Registrar's Signature



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

								G. NO.			
- 4	1. DECEDENT'S NAME (First, Midd					2.	DATE OF DE	ATH DAY	YEAR	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER		991				03	10	79	1133	
	217-14-3907	8. SEX	8. AGE (In yrs. lest	YRS. MONTH		MIN.	DATE OF BIF (Month, Day, Jan. ]	Year)	Counti	IPLACE (State or Fon y) 'yland	
	9a. FACILITY NAME (if not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH		
DIRECTOR	Canton Harbo	Ва	Baltimore County				Baltimore				
EC	10a. STATE 10b.	COUNTY	4	10c. CITY, TOWN	OR LOCATION					10d. INSIDE CITY	
	Maryland	Baltimore Cit	ty	Balt	imore					1 XYES 2 1	
BY FUNERAL	1300 S. Ellwood Street				101. ZIP COI		U.S.A.				
	11. MARITAL STATUS 1 Never Married 2 Marri 3 Widowed 4 Divorced	T EVER IN U.S. ARI YES 2 N	YES 2 NO If yes, specify Cubar			ORIGIN? (Spe uarlo Rican,	cify Yea or No—	14. RACE — American Indian Black, White, atc.  Specify: White			
		IT'S EDUCATION lest grade completed)	16a. DE6	CEDENT'S USUAL	OCCUPATION	do a	16b. KIND	OF BUSINESS/IND	USTRY		
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 6 +	ille.	Do NOT use retired	etary	ang	R	ailroad			
ш	17. FATHER'S NAME (First, Middle, Joseph Patr				18. MO	yrtle	(First, Middle, Blanc	Maiden Sumame) he Harri	s		
TO B	19a. INFORMANT'S NAME (Type/Pr Unknown	rint)	19ts	Unknown	ESS (Street and Numb	er or Rural Routi	Number, City	or Town, State, Zip	Code)		
	20a. METHOD OF DISPOSITION 1 Burlet 2 Cremation 3	☐ Ramoval from State		AND DATE OF DISP			DATE	20c. LOCATION —	City or To	wn, Stata	
	4 Donation 5 Q Other (Spec	olfy)	- Comotory, crea								
	21. SIGNATURE OF FUNERAL SEPTEMBER 1	d'S, Wade, D	irector	2	25tate AR Baltimor				. Bal	ltimore	
	26. PART I. Enter the disees	ses, or complications that	t coused the de	eth. Do not ent	er the mode of d	ying, auch e	e cerdiac o	r reapiratory arr	reat,	Approxima Interval Be	
	shock, pr heert										
	and the second s	agent a									
	disease or condition resulting in death)	a	er can								
		a	(OR AS A CONSEC	DUENCE OF):	/	Anso	2100				
NO	resulting in death)  Sequentially list conditions,	DUE TO	OR AS A CONSEC	OUENCE OF):	I mon a	y 875°	386	,			
CATION	Sequentially list conditions, if any, leeding to immediate couse. Enter UNDERLYING	DUE TO	(OR AS A CONSEC	OUENCE OF):	I mon as	y 875°	-45C	,			
IFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease pr injury that initiated events	b. DUE TO	OR AS A CONSEC	DUENCE OF):  OUENCE OF):	lmonal	y \$7.5°	286	,			
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Schuler Hans March 20 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore Rehabilitation and Extended Care Baltimore IN Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Months Deys Hours Min. (Month, Day, Yeer) Baltimore N/A 5. Sociel Security Number Birthplace (State or Foreign Country) 86 Yrs. 219-16-6796 Usuel Residence of Decedent 10e. State 10b. Count 10c. City, Town or Location 10d. toside City Limits N/A Baltimore 1X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 E. Lafavette Ave 21202 USA 12. Wes Decedent Ever in U,S. Agned Forces?

1 Yes 2 No If Yes, Give Year or Dates: 42-45 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Sculpture School 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Hans Schuler Paula Schneider 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Schuler /wife 7 E. Lafayette Ave Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete March 22 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 1999 Catonsville, MD 21. Signature of Funeral Service Licensee Connective full eral Home of Dundalk 7110 Sollers Point Rd 21222 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heert failure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth Alzheimer's type Dementia Immediete Ceuse (Flnal diseese or condition resulting in deeth) Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or es e consequence of) Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Cardiac valve replacement, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? 24a. Was en autopsy performed? pacemaker sick sinus syndrome Chronic obstructive pulmonary disease 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medicel examiner?

1 Yes 2 No 26. Piece of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Watural 5 Pending Investigation 1 Tyes 2 No 3 Sulcide 6 Could not be

The law requires that the deeth certificate be executed Box 68760. P.O. I Records. Division of Vital

physicien end s the buriel-transit or Attending Physician: filled in by the funeral After death. efter death To the Hospital within 24 hours a To the Funeral Completely filled Hospital

Medical

**Physician** 

/Medical

Examiner

MD

Director

Funeral

by

Completed

Be

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

"natural",

I Hygiene.

permit. Pages 1 end 2 should be filed wit Department of Health end Mental Hygiens Important: If tem 27 Is marked other tha any Injury or other traumatic event, Tasloone.

Physician /Medical

Examiner

72 hours efter

altimore, Maryland 21215-0020

Physician/Medical Examiner Be Completed Certification: To 4 Homicide 29e. Certifier

State Registrar

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end menner es steted.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature and title of certifing M

29c. License number

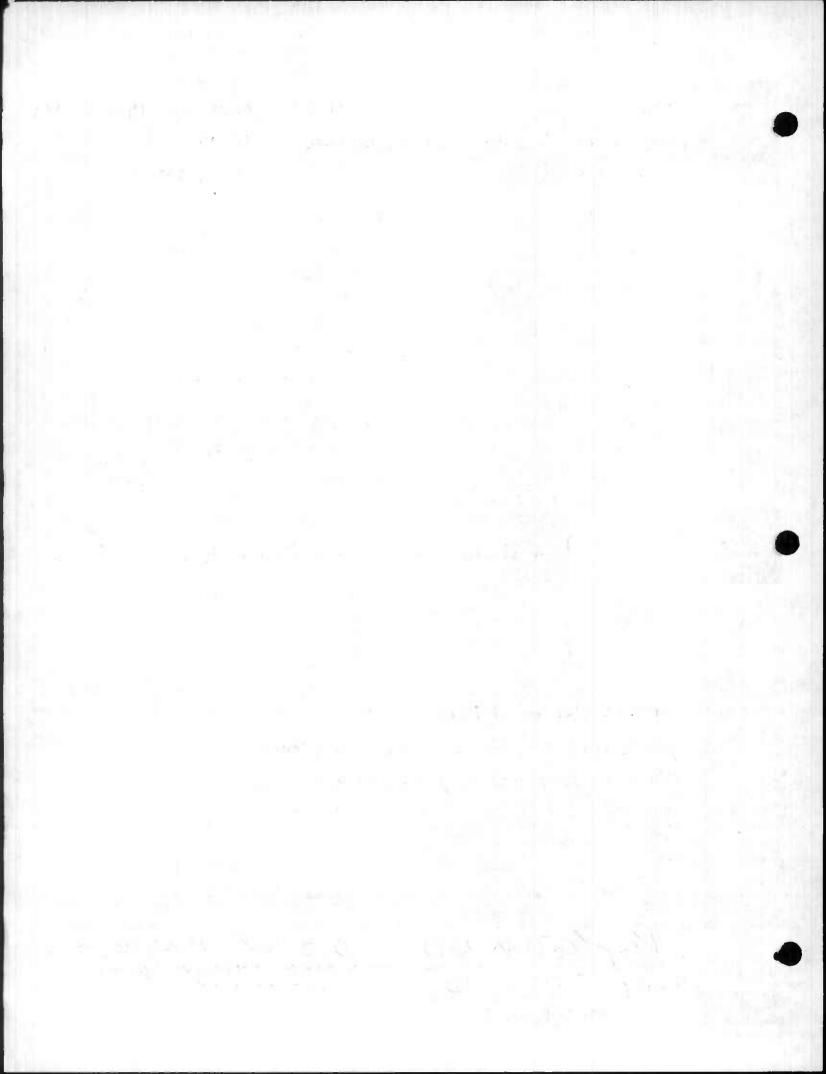
29d. Date signed (Month, Day, Year) March 20, 1999

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Ham 23e) (Type, Print) to North Greene Street
PERY L COLVIN MD Baltimore

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) 32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Data of Deeth 3. Time of Death Physician SE WILLAM 5:15 AM MARCH /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE
If Under 24 Hrs. 8. Dete of Birth
(Month, Dey, Year) Home SAMARITAN NURSING NA If Under 1 6. Sex 5. Sociel Security Number 7. Age (In yrs. lest firthday) Birthplece (State or Foreign Country) **Funeral** 18 M 2 F Months Deys 220-14-629 Director 24,1926 40 Usuel Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show be nothing Director 1 Nes 2 No BALTIMORE Md 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 21286 45 A Examiner must KAUEN 8466 LOCH Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, Whita, etc. 11. Maritel Status Armed Forces?

1 ⊠Yes 2 □ No
If Yes, Give
Year or Detes: filed within 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 KNo Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced The Medical Decadant's Usual Occupetion
 (Give kind of work done during most of working
 lifa. DO NOT use retired) 15. Decadent's Education 16b. Kind of Businass/Industry (Specify only highest grade completed) than Elementery/Secondery (0-12) Collega (1-4or 5+) 12 CEMENT NA CHAUFFER 17. Fether's Neme (First, Middle, Last) Be 18. Mother's Neme (First, Middle, Meiden Surname) Pages 1 and 2 should be Health and Mantal permit. Pages 1 and 2 should be Department of Health and Mantal Importent: If Item 27 Is marked of any Injury or other traumatic ev 2 SEAL JAMES MILDRED 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stele, Zip Code) KAUEN Blud. EVELYN L.
20e. Method of Disposition SEAL 466 BAHO NU, 21286 LOCH 20b. Plece of Disposition (Name of cemetery, crametory or other plece) 20c. Location - City or Town, State Dete 20/99 1 ⊠Burlal 2 □ Crametion 3 □ Removel from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) OF FAITH BALTIMORE CO. GARDENS 21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility ER FUNERAL HOME, CHTD-HARTLEY MITTER FUNERAL HOME, CHTDiller REFORD 7527 e or complications that caused the daath. Do not enter the mode of dying, such as cerdiac or respiratory errest List only one cause on each lina. 23s. Pert1. Entar the diseese shock, or haart failure. Intervel Between Onset and Deeth Physician Muti Francil Immediata Cause (Final disease or condition resulting in death) /Medical **Examiner** Physician/Medical Examin The law requires that the death certificate be axecuted sician and burial-trans Sequentially list conditions, if eny, laading to immediata cause. Enter Underlying Causa (Disaase or Injury that initiated events Due to (or es e consequença of): that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box ( P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobecco use contributs to the ceuse of deeth? signed by 2 NO 3 Probably 4 Unknown 1 Yes 1245PHAGA Records. by Demonation 2° MSPONGOUS Completed 24b. Wara autopsy findings evailable prior to 24a. Was an autopsy performed? completion of cause of deeth? 1 Yes 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attending Physician: director. 25. Wes casa referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 | Inpatient 2 | ER/Outpetient 3 | DOA this 27. Mannar of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After Division Naturel 5 Pending investigation Injury death. 1 ☐ Yes 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide In by t 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, daeth occurred et the time, dete and place, and due to the cause(s) end mennar as stated.

| Certifying Physician: To the best of my knowledge, daeth occurred et the time, dete and place, and due to the cause(s) end mennar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. edicai 29a. Certifier completaly 29b. Signature end tifle of certifian 29c. License number 29d. Date signed (Month, Dey, Year)

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State Registrar

32. Registrer's Signature MAR 2 3 1999

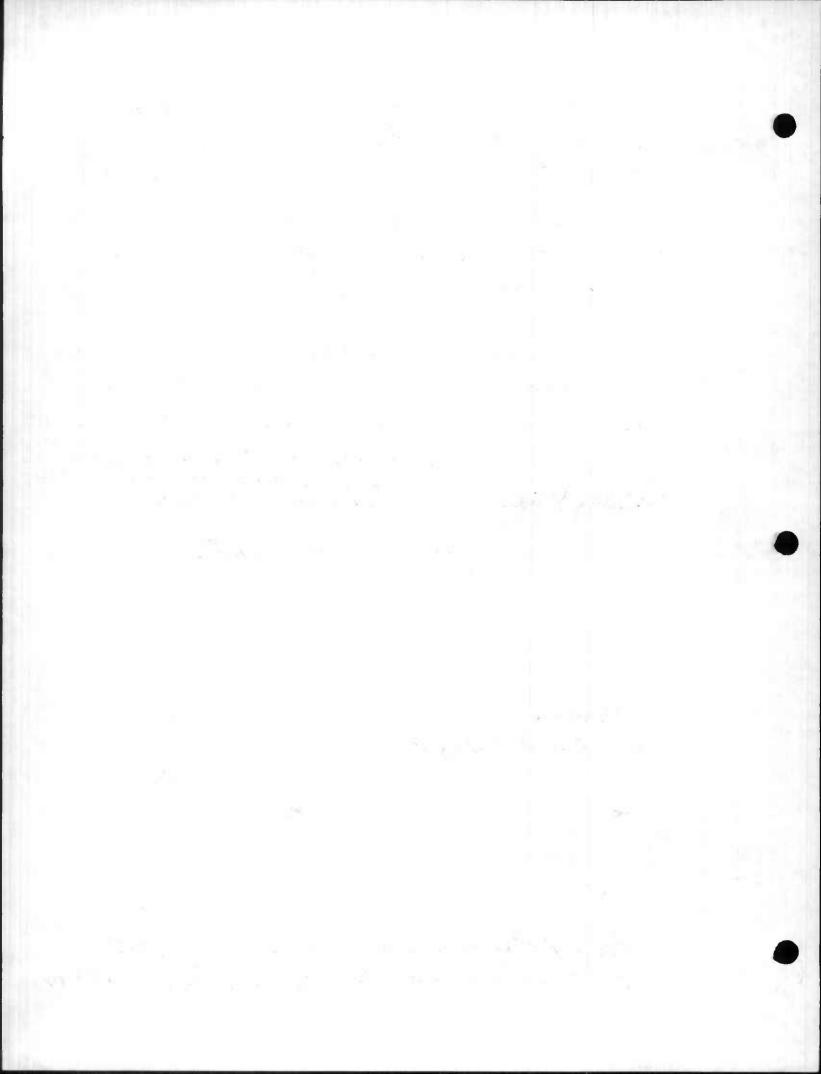
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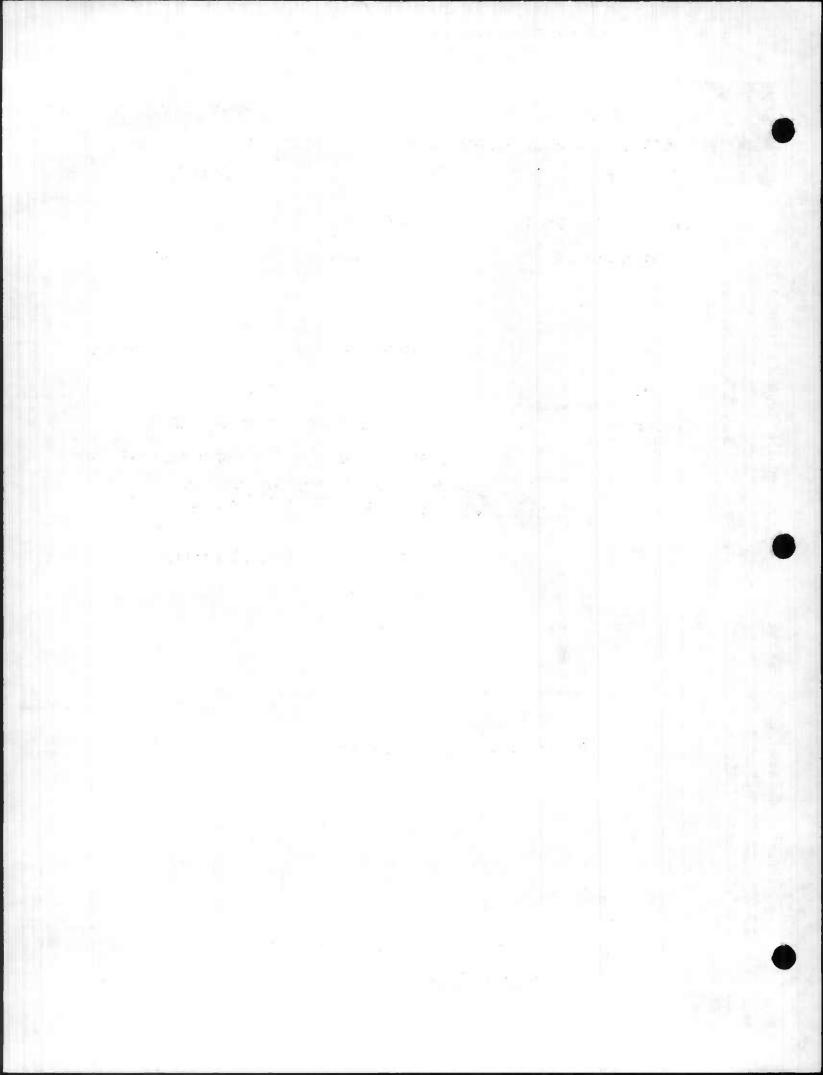


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death Month **Physician** 19 1999 MARCH WILLIAM A. TAYLOR
4a Facility Nama (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER HAMILTON - GENESIS NURSING BALTIMORE 8. Data of Birth (Month, Pay, Yaar) SEPT 12 191 If Undar 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthpleca (Stata or Foreign Country) **Funeral** 18 M 2□ F Months Days Hours 83 216 01 3933 MARYLAND Director Usual Rasidance of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at 1 Yas 2 No Director RAPSEBURG MD BALTIMORE 10a. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with permit. Pages 1 and 2 should be filed within 72 hours efter death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "--- any Injury or other traument— page. 21206 4300 RAYMAR AVE USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑No If Yes, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amaricen Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Nevar Married 2 ☐ Married Specify: WHITE 1 ☐ Yas 2 X No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) College (1-4or 5+) Elementery/Secondary (0-12) RAILROAD WAREHOUSE UNK UNK 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be UNK UNK. UNK 0 UNK 19b. Melling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Typa, Print) 4300 RAYMAR AVE BALTOIMORE, MD21206 DOROTHY EMERY / FRIEND 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20c. Location - City or Town, Stata 20a, Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata HOLY REDEEMER 3/22/99 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility
CVACH/ROSEDALE FUNERAL HOME 21. Signature of Fuheral Service Licensas 1211 CHESACO AVENUE BALTO, MD 21237 enis 23a. Part1. Enter the disease, or complications the caused the death! On not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediata Ceuse (Finel disaasa or condition resulting in daath) **Examiner** Examiner OP the death certificate be executed physician end the buriel-tran Sequantially list conditions, if any, laeding to immadieta ceuse. Entar Undarlying Cause (Diseese or injury that initiated avents rasulting in daath) Last Due to (or as a consequance of): Division of Vital Records, P.O. Box 68760 CHF Physician/Medical Dua to (or as a consequence of): 98 USB ŏ 23b. Did tobacco use contribute to the cause of death? Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. the signed by t 1 No 3 Probably 4 Unknown EMENTIA by 24b. Wara autopsy findings available prior to 24a. Wes en eutopsy performed? Completed ARKINSON'S DISCASE complation of ceusa of death? hes 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate or Attending Physician: after death. Director: After this certific director, 25. Wes case refarred to medical axaminar? Be 26. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 □Othar (Specify) 1 Yas 2 No 10 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA funeral 27. Menger of Deeth Certification: 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel 5 Pending invastigation 1 Yas 2 No 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of tnjury - At homa, farm, straat, factory, office building, atc. (Spacify) in by 4 ☐ Homicida Hospital edical 1 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 29a. Cartifiar 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. To the I 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) BHALODIYA 30. Name and address of person who Harkway Baltimore, 32. Registrar's Signetura 31. Data filad (Month, Day, Year) State MAR 23 1999

Bines

**DHMH 16 Rev 6/95** 

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 20 De Month **Physician** Guy Wilson Tucker III 5:30 AM drch /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 7/P/BULLING
1 Under 24 Hrs. 8. Dete of Birth
(Month, Day, Yee
Dec. 18, Examiner If Under Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. Jast birthday) **Funeral** Months Days 1X) M 2 F 52 216-44-6577 1946 Maryland Director Usual Residence of Decedent the Manylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits trithen "netural", or flems 23e or 28e-f ahow Anne Arundel Crownsville 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1786 Severn Chapel Road 21032 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 72 hours after 1 Never Merried 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: White p 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mentel Hyglene. Important: if item 27 is marked other than "n any injury or other treumatic event. In each Elementery/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor Housing 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Guy Wilson Tucker II Evelyn Leese Morfoot 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Evelyn Howe (Mother) 1131 Fernlea Road, Tappahannock, VA 22560 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Metro Crematory 03/22 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Euneral Service Liceny 22. Name and Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final LIVER GRRHOSIS disease or condition resulting in death) Examiner Examiner ALCOHOL HEDATITI physician and the buriai-transit that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Due to (or as e consequence of) Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 3 Probably 4 ™Onknown 1 Yes 2 No ģ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24e. Was en eutopsy performed? 1 Yes 2 No 1 Yes 2 No 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28d. Describe how injury occurred 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Attending 1 Matural 5 Pending investigation deeth. 1∏ Yes 2∏No ie Hospital or Atlandi n 24 hours eiter deeth se Funerel Director: / pletely filled in by that 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tells of certified 29c. License number 29d. Dete signed (Month, Dey, Year)

State Registrar

more, Maryland 21215-0020

Box 68760

P.O.

Records,

Division of Vital

31. Date filed (Month, Day, Year)
MAR 2 3 1999 82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

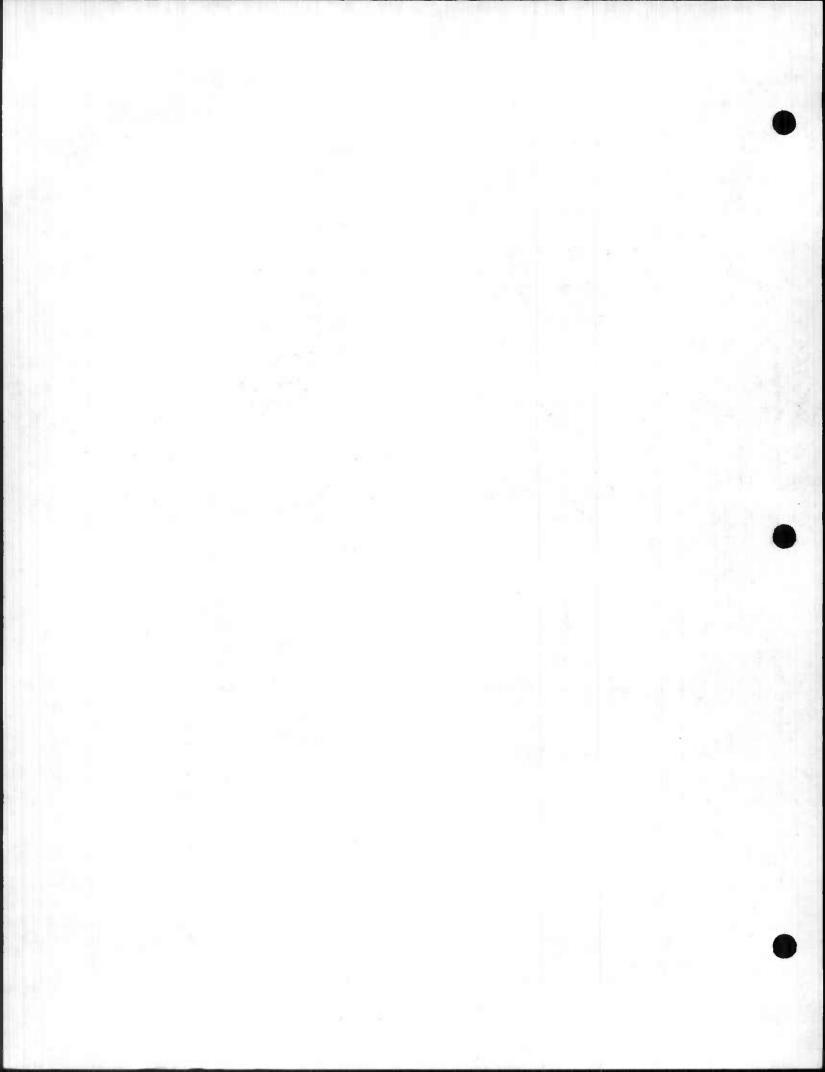
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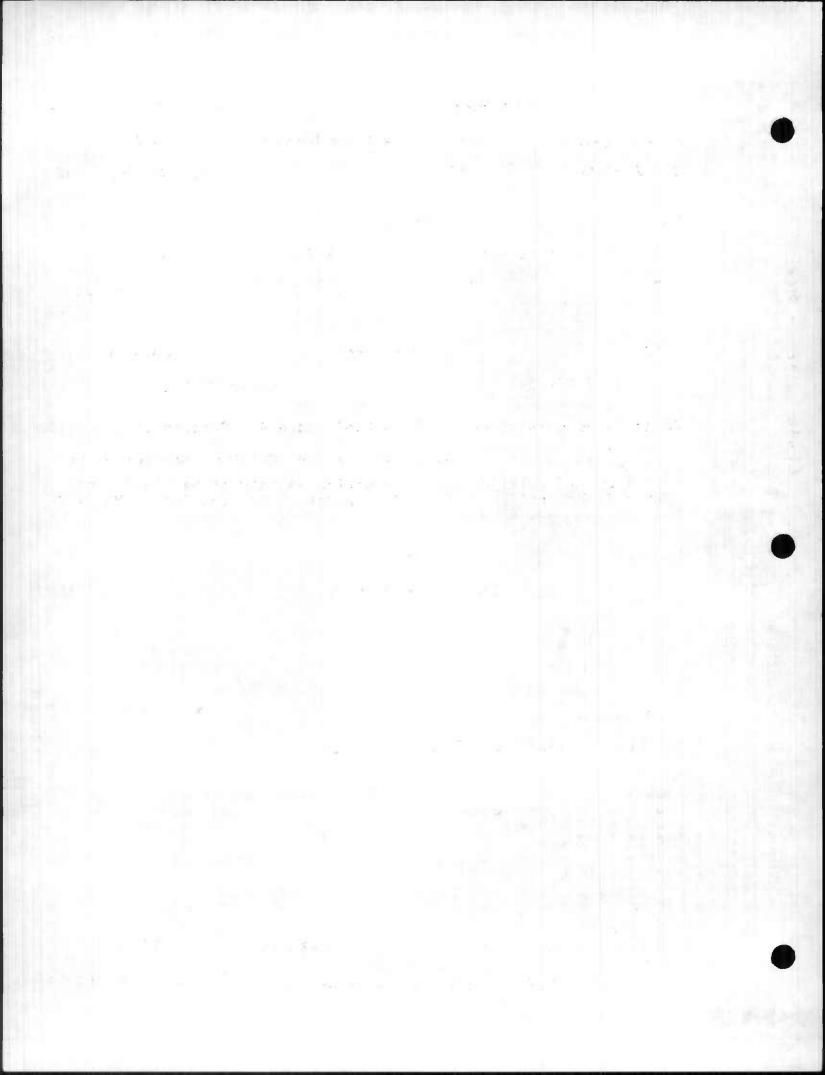
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Registrar

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notified at		10e. Stete 1	0b. County			loc. City, Town or								10d. Inside City Limit:
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0 8 0		10e. Street end Numb	er				10f. Zi	p Code				0g. Citizen o	f What Co	untry?
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29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, and due to the ceuse(s) end menner es steted.

2 Madical Examinar: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end piace, and due to tha ceuse(s) and menner stated.

29c. License number 29d. Date signed (Month, Day, Year)

OCME MARCH 17, 1999

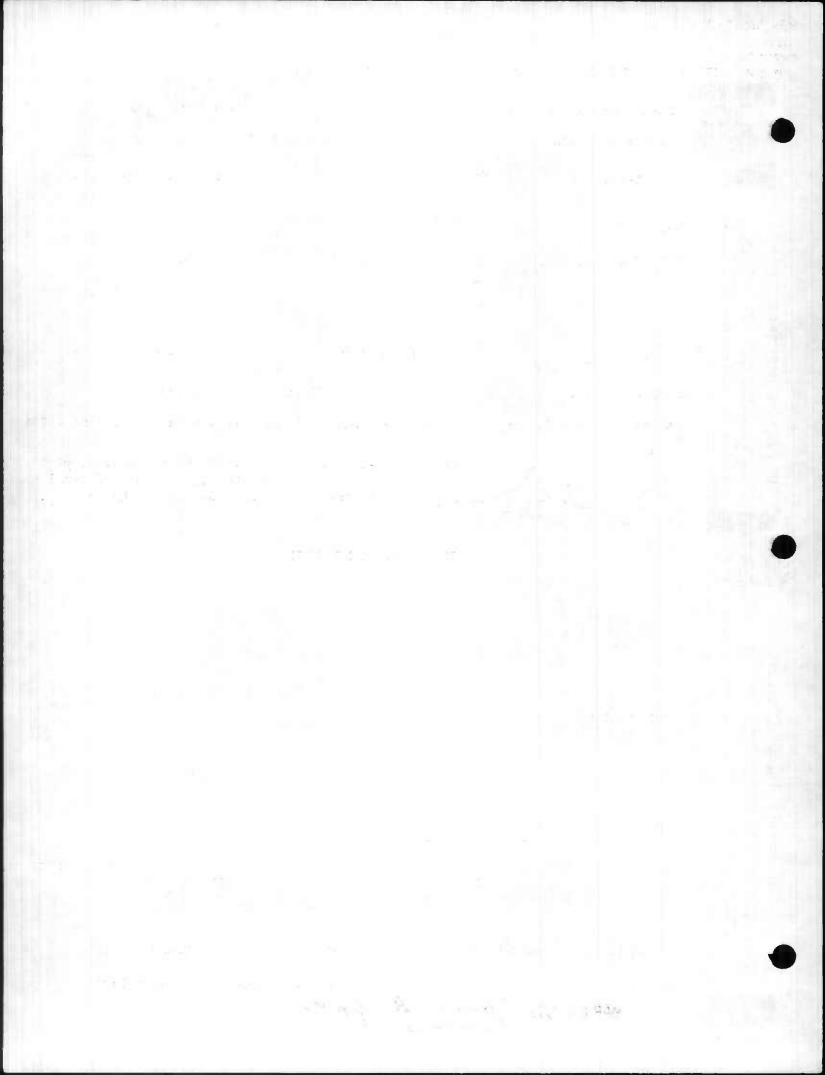
address of person who completed ceuse of deeth (Item 23e) (Type, Print) A. KOROL MB MINGDOND

111 Penn Street, Baltimore, Maryland 21201

State Registrar

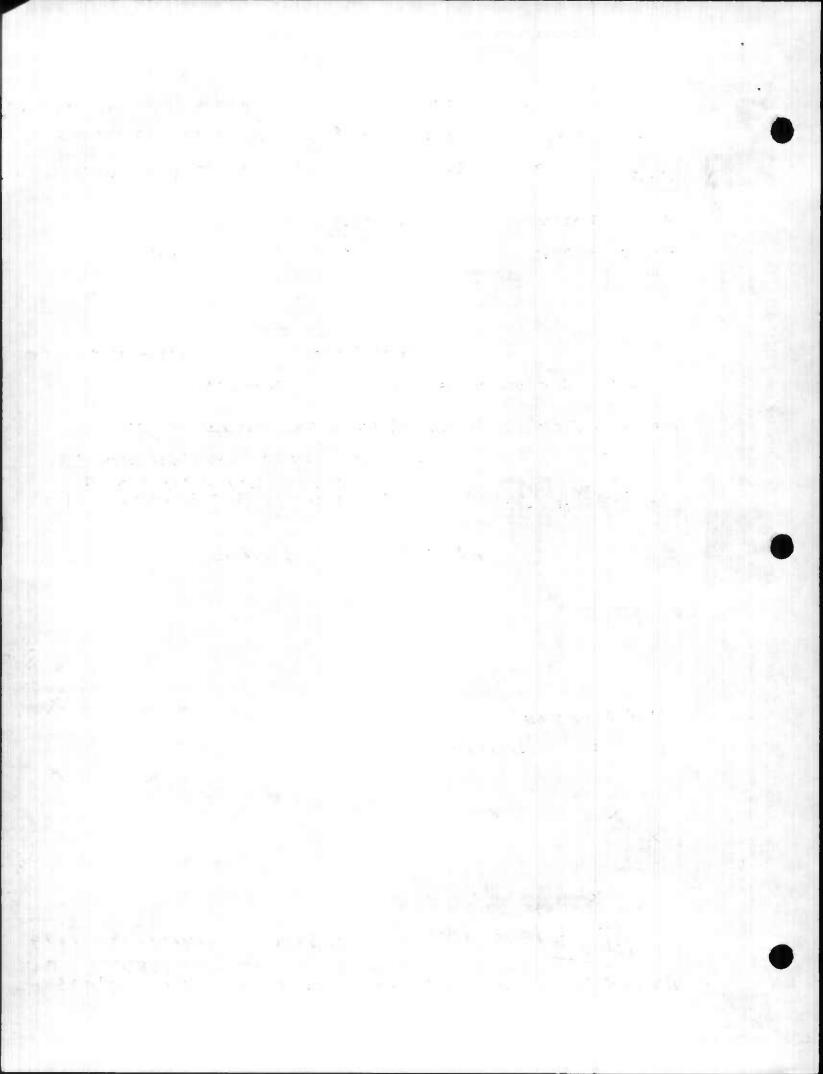
Medicai Ce





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 2. Date of Death Month **Physician** SIDNEY WICKS 08:34 Pm 1999 /Medical 4e Fecility Neme (If not institution, give straet and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner CENTER LAOSPITAL RANDALLSTOWN BALTIMORE. NORTH WEST 8. Data of Birth (Month, Day, Year) MAR 27, 19 If Undar 1 Year | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 X M 2□ F Months Deys Hours Min 46 Yrs. Maryland Director 214-62-5085 Usual Rasidenca of Dacedan the Marylend 10d. Insida City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No Baltimore Director Baltimore 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code Peges 1 end 2 should be filed within 72 hours efter death with 1 end of hauth and Mental Hygiena.
Int: if item 27 is marked other than "natural", or items 23a or imy or other transmission with the Medical Exercise man by or other transmission. 3103 Donna Road 21207 USA Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarlo Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 2 No If Yas, Give Yaar or Datas: 14. Race - Amarican Indian, 11, Marital Status Bleck, Whita, atc. Navar Married 2☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced 15. Decedant's Education 16a. Dacedant's Usual Occupation 16b. Kind of Businass/Industry (Give kind of work dona during most of working life. DO NOT usa ratired) (Specify only highest grede complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Clerk/Typist State of Maryland 18. Mothar's Nama (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Andrew Glenford Wicks, Jr. Pearl Adams 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) Andrew G. Wicks, Jr./father 3103 Donna Road Baltimore, MD 21207 20b. Placa of Disposition (Neme of camatary, cramatory or other placa) Date 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burlai 2 Kramation 3 Ramoval from Stata permit. Pege Department of Important: if any injury or once. Metro Crematory, Inc. 03/22/99 Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licensae <sup>22</sup> Nama and Address of Facility Cremation Society of Maryland, Inc. Dawn F. McDonald 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not anter tha moda of dying, such as cardiec or raspiratory arrast, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final CARCINOMA 012 LUNGS disaasa or condition resulting in daath) Examine Dua to (or as a consequanca of): Examiner physician and the burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediata causa. Enter Underlying Causa (Disaasa or injury that initioted avants rasulting in daath) Last Dua to (or as a consequanca of): Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION' by 24b. Wara autopsy findings eveilable prior to complation of causa of deeth? Completed 24e. Was an autopsy MELLITUS . DIABETES Is certificata her 2 0 No 1 ☐ Yes 1 Yas Division of Vital al or Attending Physicien: The safter death.

I Director: After this certificated in by the funeral director, pa 25. Was casa referred to medical Be 26. Placa of Daeth (Chack only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 XInpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Mannar of Death 28b. Time of 28d. Dascribe how injury occurred 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 ☐ Suicida 281. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI completaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, end due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar stated. Medical 29a. Cartifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signatura and the of cartified PHYSICIAN HOUSE D42723 MARCH 3745 FORFORD STREAM 30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print) BALTIMORE AVVERAHALL HARISH 32. Ragistrar's Signature 31. Data filad (Month, Day, Year) State 3 1999 Registrar



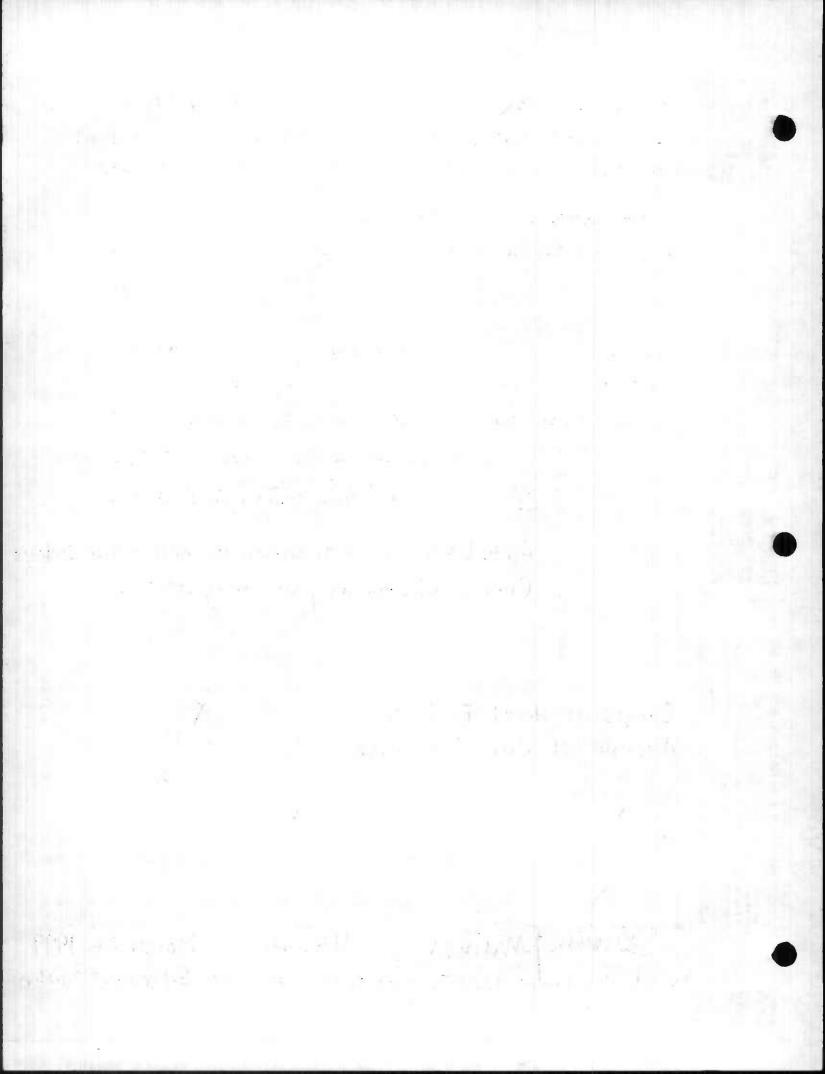
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cal ner	4a Facility Name (If not instite MILFORD MANO				V V And die Ver		1	6b. City, To		MARCH cation of Death	4c. County	999 of Death IMORE	1:48AM
al or	5. Social Security Number 213–20–9328	6. Se:		. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under:		8. Date of Birth		9. Birthple	
	Usual Residence of Deceden	t										MARYI	AND
tor	10a. State 10b.Co	'Aty			ty, Town or Lo	RE						10	d. Inside City Limits 1 Yes 2 □ No
Funeral Director	10e. Street and Number 6400 ELRAY DR	IVE A	APT. D			10f. Zip.	2120	9		10	og. Citizen of V	that Countr	y?
	11. Marital Status  1 Never Married 2 1  3 Widowed 4 Divor	Married	12. Wes Deced Armed Ford 1   Yes 2 If Yes, Give Year or Det	æs? E⊠No		Wes Deced If Yes, spec	ify Cuba	lispanic Origin, Mexican Specify:	gin? (Spe , Puerto I	cify Yea or No- Rican, etc.)	Blac	e - America ck, White, et WHITE	
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	17. Father's Nama (First, Mids UNOBTAINABL			OBERN OEBI	MAN ERMAN				r's Nama ESSII	(First, Middle, M			INABLE
	19a. Informant's Name/Releti					ng Address SEVEN				I Route Number, BALTIMOR			Code)
	HELEN COHEN/D  20a. Method of Disposition  11 Burial 2 Cremeti 4 Donation 5 Othe	on 3□R	ternovel from Si	late MIK	Plece of Disposition (CO)	osition (Name	ne of	ÎSRAE			20c. Location		
	21. Signatura of Furnisa Sery		11/	zer	22	2. Name end	d Addre	ss of Fecilit	SOI	L LEVINS			
Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated eventa resulting in death) Last	{	. A	Due to (c	or as a consecutive as	quence of):	RI	ncovo	2 Zi	, Man	llise	are	
il	Part II. Other significant cond	ditions con	ntributing to dea	th but not res	sulting in the u	nderlying ca	ause giv	en in Pert I.			becco use co		the cause of death?
i	Can. Q.	-0	1-76 V	D. T	FCA	lear	10 0						
A. C.	Cangol	ie	Her	the	, Fca	راص	ره			24a. Was ar perform	n autopsy ned?	avai	e autopsy findings lable prior to
Completed by	Carpel		Her	L-S	Fa	رامه	-0			24a. Was ar	ned?	com of de	e autopsy findings lable prior to pletion of cause sath?
Be Completed by Physician/M	25. Was case referred to med examine?	-	denite h	T.e	Fa	100			of Deeth	24a. Was ar perform	ned?	com of de	lable prior to pletion of cause sath?
to percombiered of	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Per	H	lospitat 1 In		ER/Outpatie		8c. Injur Wor	er: 4□ Nå	reing Hor	24a. Was ar perform	ned?  na 2 No  no 6 □Ott	avai com of de 1 □	lable prior to pletion of cause seath?
To Be Completed by	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pe  2 Accident inv  3 Suicide 6 Co	H	28e. Data of (Month)	Injury , Day Year)	28b. Time of Injury	M 21	8c. Injur Wor 1 🗆	er: 4□ No yat k?	No 2	24a. Was ar perform  1  Ye  (Check only one	ned?  No e) nce 6 Otherwinjury occur	availacom of did	lable prior to pletion of cause eath?  Yes 2 No
edical Certification: To Be Completed by	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  1 Certifier 2 Media	nding estigation uld not be emined fying Physical Examin	28e. Place of building	Injury Day Year) Injury - At h g, etc. (Special est of my known is of examina	28b. Time of Injury oma, farm, att	M 21 M reet, factory h occurred a vestigation,	8c. Injury Word 1	y at k? Yes 2 1	No 2	24a. Was ar perform  1 Ye  (Check only one na 5 Raside 28d. Describe ho  28f. Location (St. City or Town	ned?  No  No  No  No  No  No  No  No  No  N	der (Specify) red  anner as sta and due to to	lable prior to pletion of cause eath?  Yes 2 No  Route Number,  ted. the cause(s)
Completed by	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Per 2 Accident 3 Suicide 6 Co 4 Homicide  29a. Certifier (Check only 2 Media	nding estigation uld not be ermined syling Physical Examire tiffer	28e. Data of (Month). 28e. Place of building selctan: To the basend manner.	Injury Day Year)  Injury - At h p, etc. (Special est of my kno is of examinal r stated.	28b. Time of Injury oma, farm, at fy) owledge, deet tition and/or in	M 21 M reet, factory h occurred a vestigation,	8c. Injury Word 1	y at k? Yes 2 1	No 2	24a. Was ar perform  1 Ye  (Check only one na 5 Raside 28d. Describe ho  28f. Location (St. City or Town	ned?  No  No  No  No  No  No  No  No  No  N	der (Specify) red  anner as sta and due to to	lable prior to pletion of cause eath?  Yes 2 No  Route Number,  ted. the cause(s)

32 Registrar's Signature

Registrar **DHMH 16 Rav 6/95** 

31. Date filed (Month, Day,

MAR 2 3 1999



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month eaver warch 11am 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number, 4c. County of Deeth allimore Hospital wind 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 10 M 20 F Months Days Hours 218-44-020Z Usuel Residence of Decedent Yrs. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE NA 1 Yes 2 No MD 10e. Street and Number 10g. Citizen of Whet Country? USA 4615 21215 Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 11. Marital Status Bleck, White, etc. APrician 1 Never Married 2 ☐ Merried 1□ Yes 2☑No Specify 3 ☐ Widowed 4 ☑ Divorced American 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer NA Cleaning 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Gracie James Weaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 51.5Ter BATIMON, MD. ZIZIZ 908 BArbara M. Huggins 100 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burlal 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility WYLIE 7HIPA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or shock, or heart failure. List only one cause on each line. BALTIMORE, MJ. 21217 Approximete Intervel Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentielly list conditions, if erry, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last ruena vman 23b. Did tobacco use contribute to the cause of death? Pert II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given In Pert f. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 22 No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner thet the death certificate be executed

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f shot traumstic event, the Modical Examinar must be notified at

with the Marylend

72 hours after death

Hygiene.

end Mentel

t of Health e

Important: If Its any injury or o

William Weaver

Common on

Examiner physician end the buriel-transit Physician/Medical ettending ph signed by the e by Completed Be

After this certificate hes funeral director, page 2 2 Certification: death.

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

efter deatl Director:

n 24 hours efter ne Funeral Direct pletely filled in b

To the Hosp within 24 hor To the Fune completely fi

25. Wes case referred to medical examiner? 1 Yes 2 No

27. Menner of Deeth 5 Pending investigation 1 Natural 2 Accident 6 ☐ Could not be determined 3 Suicide

4 ☐ Homicide 29a. Certifier (Check only one)

1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated.

28d. Describe how injury occurred

29b. Signature and title of certifier

29c. License number

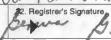
29d. Date signed (Month, Day, Year)

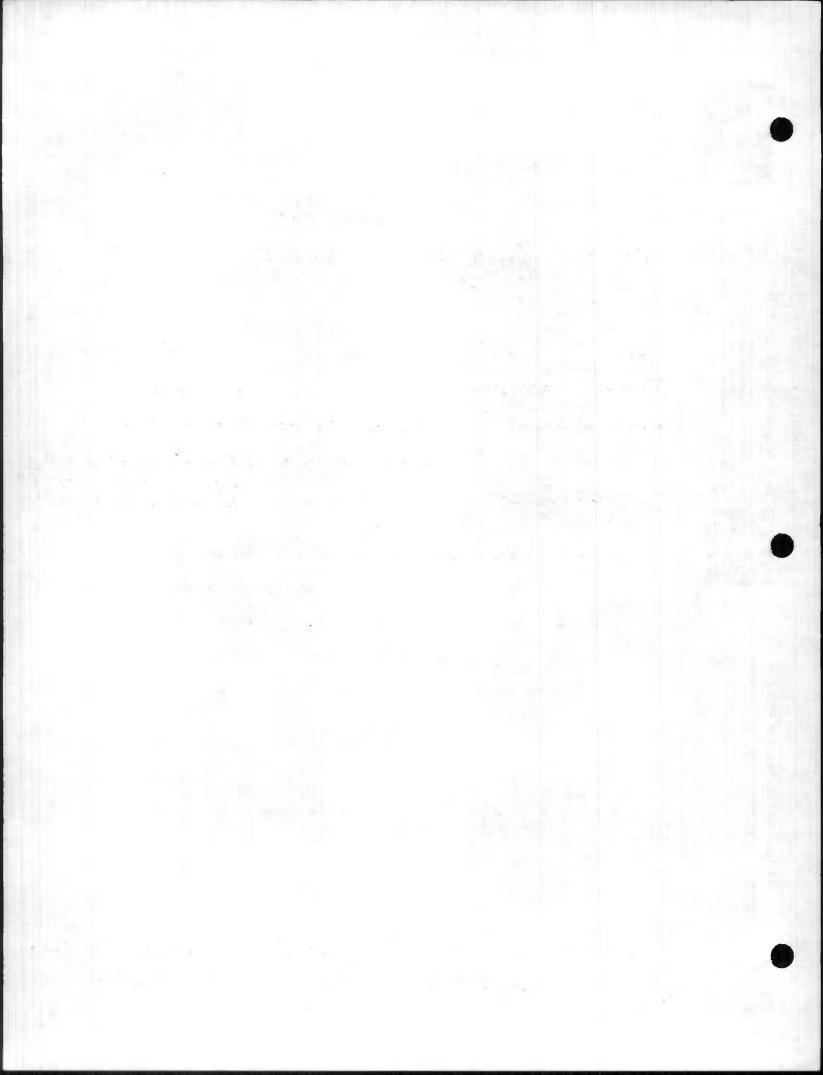
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schedere 240 Cula Gancis

State Registrar

Medical

31. Dete filed (Month, Day, Year) MAR 2 1999





Please Type or Print in Biack indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 3140 AM NORMAN 400NG 1999 16 MARCH 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) 1+05 postal NA 9000 BALTIMORE Samaritan 7. Age (In yrs. lest birthday) If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. (Month, Deys Yeer) 5. Social Security Number Birthplece (State or Foreign Country)
 TT A 1 M 2□ F 220-14-6947 VA. Usuel Residence of Decedent 10a Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 111 WEST RD. 21214 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14 Rece - American Indian 11. Maritel Stetus Bleck, White, etc. 1 √ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) NURSING ASSISTANT HEALTH CARE 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) NORMAN F. YOUNG SR. UNKNOWN 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) BESSIE CLAYBORNE(SISTER) 1623 WINFORD RD. BALTIMORE, MD 21239 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) METRO. CREMATORY 3-19-99 BALTIMORE, MARYLAND 22. Name end Address of Fecility PHILLIPS FUNERAL HOME, P.A. 21. Signeture of Funeral Service Licensee aresta Sheta CFSP 1721-27 N. MONROE ST. BALTIMORE, MD 21217 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heer failure. List only one ceuse on each line. Onset end Deeth Immediate Cause (Final disease or condition resulting in deeth) SEPSIS Due to (or es a consequence of): STA6E RENAL DISEASE END Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Hypertension Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 No Unknown 24b. Were autopsy findings eveileble prior to 24a. Wes an autopsy parformed? completion of ceuse of deeth? 1 Yes 2 No 1 Yes 2 ANo 28. Piece of Deeth (Check only one) Hospital: 1 La Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28h Time of 28d. Describe how injury occurred

Examiner siclan and burial-transit certificata be executed physiclan s the burial Box 68760. ed by the detached Records, P.O. signed by to peen : cartificate has b lirector, page 2 s Division of Vital this After this Attending death. Ne Hospital or Attendi n 24 hours after death. Ne Funeral Director: A bletely filled in by tha fi To the Hosp within 24 ho To the Fune completely fi

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

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**Funeral** 

Director

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Maryland 21215-0020

should be fill end Mental H

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permit. Pages 1 and 2 st Department of Haalth end Important: If item 27 Is in any Injury or other traun

Physician

/Medical

Examiner

Physician/Medicai

by

Completed

Be

Certification: To

Medicai

Is merked

ified within 72 hours effer death with the Marylan I Hygiene. other than "natural", or lieme 23e or 28e-f show fent, the Medical Examinat must be notified

25. Wes cese referred to medical exeminer? 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. fnjury et Work? 5 Pending 1 Naturel 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

(Check only one) 29b. Signeture end title of certifier

31. Dete filed (Month Dey, Year)

29c. License number

29d. Date signed (Month, Dey, Year)

Cletia Negrini, M.D.

P12563

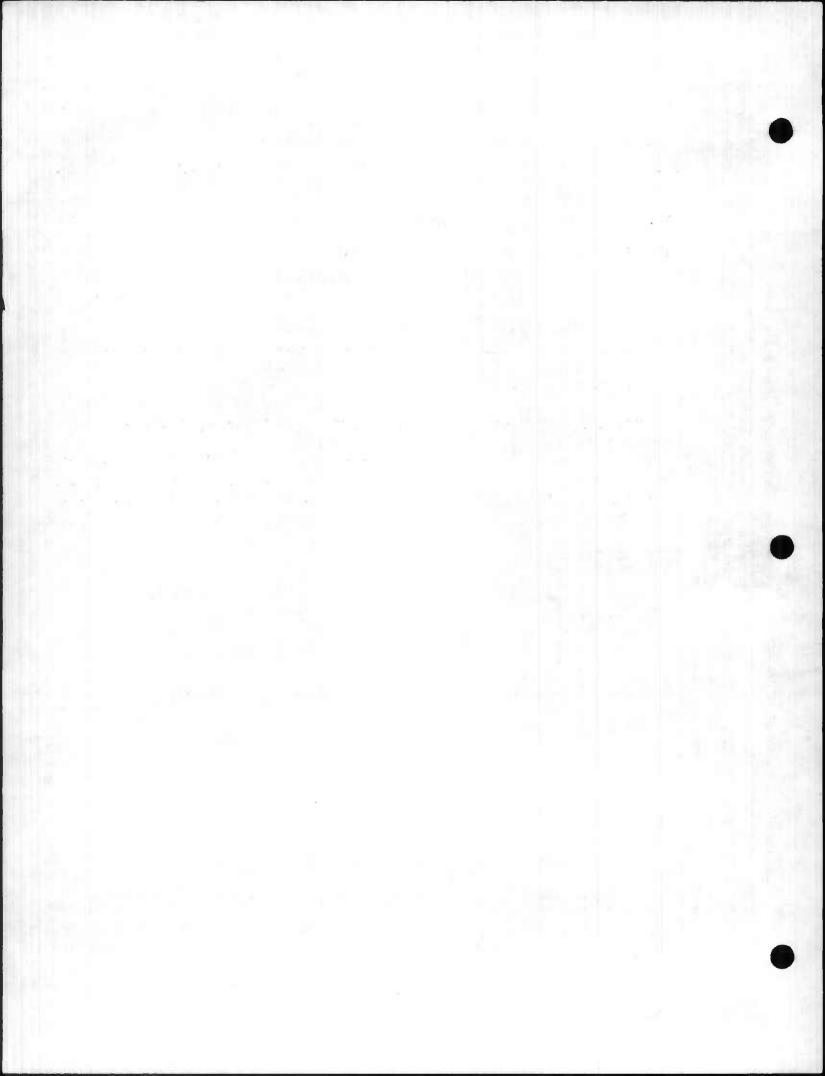
March 16 1999

Cleva Negeri, M.D.

30. Name and address of parson who completed cause of death (Item 23e) (Type, Print) 9000 Samari tan 1404 mit tal Local Raven Boulevard-BALHINDEERD

Registrar

32. Registrer's Signature



Please Type or Print in Black indelible lnk. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month YAEDE 25 AM 20,1999 AYMOND MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE NUrsing Home LOCH RAVEN H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 2 F Months Days Director 103-28-8878 MMY 5, 1936 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-1 show the Medical Examiner must be notified at 10d. Inside City Limits MD BALTIMORE 1 Yes 2 HNO Director PARKVIlle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? DRIVE 21234 NUNLE U.S.A 8312 Funeral 12. Was Decedent Ever In U.S. Armed Forces? NAVY 10 Yes 2 No If Yes, Give 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11. Marital Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1955TO 21215-0020 1 ☐ Yes 2 ☐ No Specify: specify: White by 3 ☐ Widowed 4 ☐ Divorced 1963 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12+4 CUSTODIAN DISTRICT School Baltimore, Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 Is marked othway Injury or other traumatic event sonce. 18. Mother's Name (First, Middle, Maiden Surname) KAYMOND MEDE REMENSCHNEIDER WINAFRER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) (SON) 2801 BACTO. MD 21334 Rosalie MR Michael MEDE AVE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 3/24/99 GARRISON BALTO. Forrest Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility HARTLEY MILLER FUNERAL Home Miller Has GRD RD BALTO MD 21234 7527 23a. Part1. Enter the disease, or compilcations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. pproximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Month disease or condition resulting in death) cran Examiner Due to (or as a consequenca ot): Physiclan/Medical Examiner teriovenous end I-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician er s the buriel-t Box 68760 Due to (or as a consequence ot): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. P.O. 23b. Did tobacço use contribute to the cause of death? 1 2 2 No 3 Probably 4 Unknown Intra cerebral previusm, poriph Records, Be Completed 24b. Were autopsy tindings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? Unsular disease, ATrial Espallation heart DI serge Consestive 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case reterred to medical exeminer? 28. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation To the Hoapital or Attending within 24 hours effer death.

To the Funeral Director: Afte completely filled in by the fun 1 Natural 2 Accident 1 Yes 2 No 3 Suicide 6 ☐ Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as steted. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piece, end due to the ceuse(s) and manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) March 20, 1999 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 16 north greene ST.

DHMH 16 Rev 6/95

State Registrar . ( .

MAR 2 3 1999

Herry

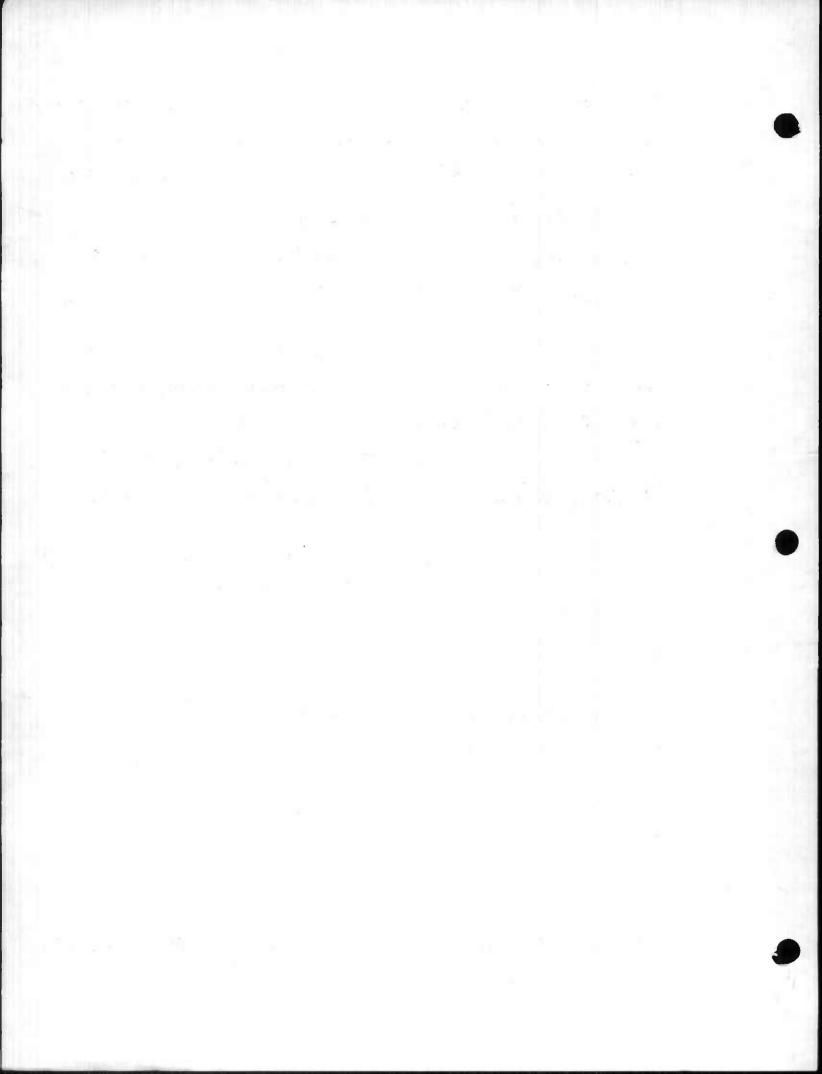
31. Date filed (Month, Day, Year)

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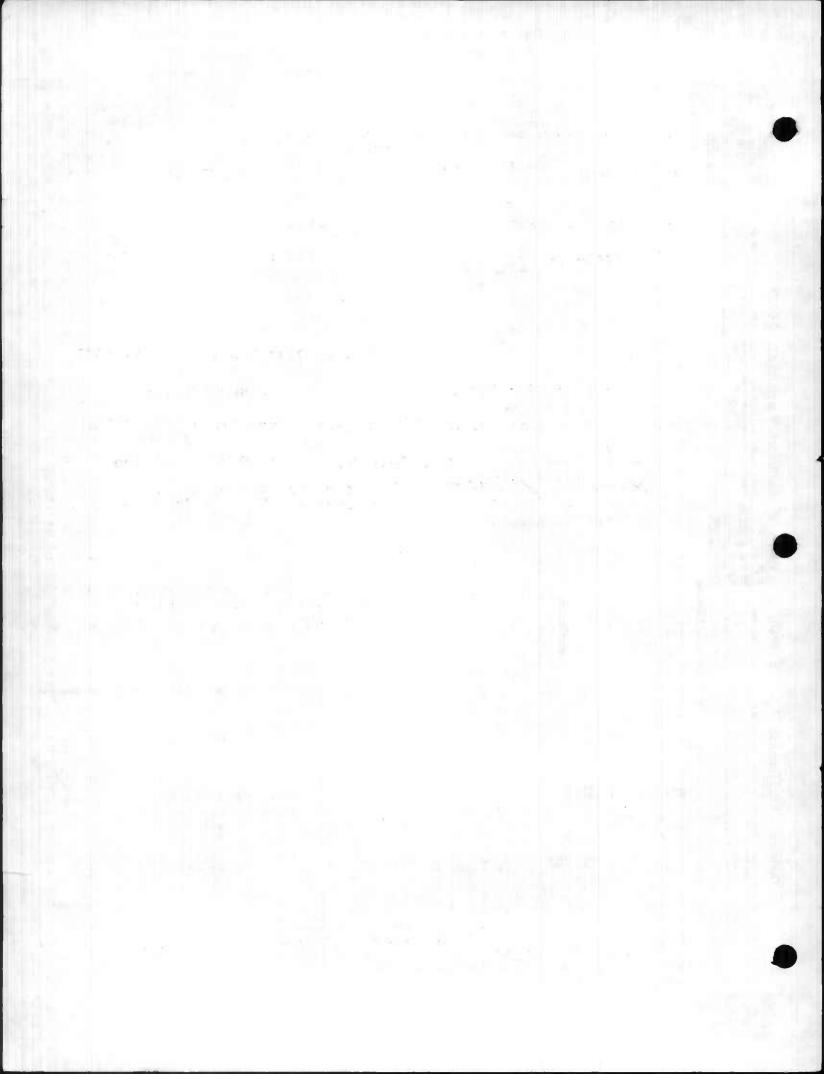
32. Registrar's Signature

Bolts



State of Maryland / Department of Health and Mental Hygiene Q Q Q L E Q

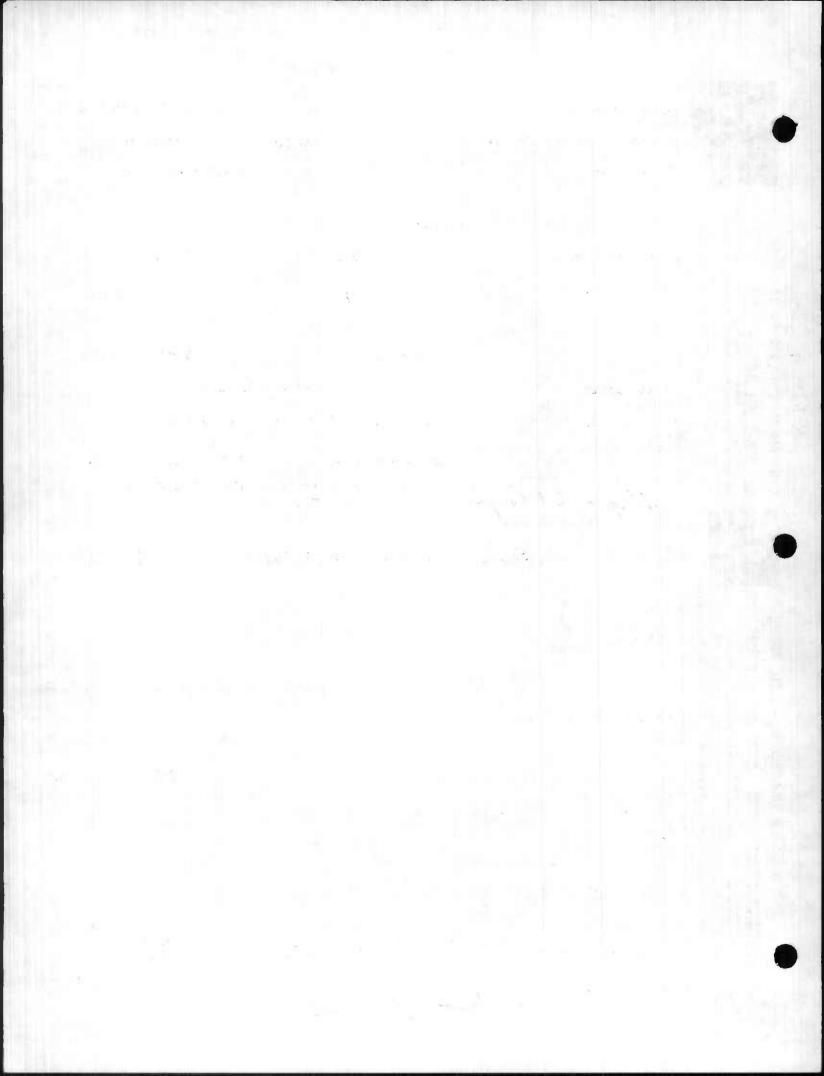
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*nature!*, or freme 23a or 28a-f show  The control of the control	5.: 2 Us 10 M 10 C	Facility Nama (If not institution, STOHNS HOPKI  Social Sacurity Number  216-25-7001  Sual Rasidance of Dacedant  I.a. Stata 10b. County  Maryland Ba  10b. Street and Number  222 Holgate D  Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorcad  15. Decedant's	ive street and number NS BA V V  Sax 1 M 2 NF 7. A  1 timore  12. Was Dacedar Armed Forces 1 1 Yas, Giva	Aga (In yrs. 59	last birthday) Yrs.  If Me	Under 1 Year porths Days	BALT( If Undar 24 Hrs. Hours Min.	MARC ocation of Death  MORE  8. Data of Bir (Month, Da	th ) 4c. County	of Death N/A 9. Birthple Count Gre	aca (Stata or Fe ry) ece
n 72 hours effer death with the Marylend *nature!, or items 23a or 28a-f show epical Examiner must be notified at	5.: 2 Us 10 M 10 G	Social Sacurity Number  216-25-7001  Sual Rasidance of Dacedant  I.a. Stata 10b. County  Maryland Ba  I.e. Street and Number  22 Holgate D  Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorcad  15. Decedant's	Sax 1 M 2 DF  7. A  1 timore  12. Was Daceder Armed Forces 1 1 Yas, Giva	Aga (In yrs.  59  10c. Cit	last birthday) If Mo	Under 1 Year porths Days	BALT( If Undar 24 Hrs. Hours Min.	M OR B 8. Data of Bir (Month, Da	th y, Year)	N/A  9. Birthple Count Gre	ece
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marke marke		Thomas V  Pa. Informant's Name/Ralationship	ardounio	tis	19b Mailing A	ddrass (Straat	and Number or Ru		Bessia er City or Town	Stata. Zip	Code)
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eges ent of ft: If I		1 ☐ Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spe		a	tro Croms		Inc. 03/	20/00	Balti	moro	MD
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Depe Depe Impo any i		George E.	MacNabb		1299	Fred	n Societ erick Ro	ad Ba	altimor		D 212
STATE OF THE PARTY.	23	<ol> <li>Pert1. Enter tha disaasa, or co shock, or heart fallura. List or</li> </ol>	omplications that caus nly ona ceuse on eech	ad tha daat line.	th. Do not antar th	e moda of dyi	ng, such as cardiac	or raspiratory a	rrast,		Approximata interval Batwee Onsat and Dea
Physician	in	amadista Causa /Final								-	Olisat and Dea
/Medical Examiner	di	nmediate Ceusa (Final seasa or condition sulting in daath)	a	SEF	2512					14	+8 HD
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executed in and faltensit			. IMMLE	NOSK	PPRESSI or as a consequan	ON SE	CONDARY ND STE	TORA	DIATIO	DV i	2 YE
n and lail-tre	Se	equantially list conditions, any, laading to Immadiate ause. Entar Undarlying ausa (Disaasa or Injury								1 1	- \/ - •
		ausa (Disaasa or injury at initiated evants	c. MEIF		7 T ( C		AST C	+NCE !	<	1 4	YEA
	ra	sulting in death) Last		Dua to (c	as a consaquam	oa org.					
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gned be de	-										
The law requires that the death cer sate hes been signed by the ettendir page 2 should be deteched for use Completed by Physiclan/A	3								an autopsy	ava	ra autopsy find ilable prior to
	2 -										nplation of caus leath?
The late he page	5							10	Yas 2 No	1□	Yas 20 No
ysician: The lav is certificate has director, page 2		. Wes case referred to medical					28. Place of Dae	th (Check only	ona)	1	
Physician: rthis certific rai director,		axaminar? 1 ☐ Yas 2 No	Hospitai:	tiant 2	ER/Outpatient	B DOA Ot	har: 4 Nursing H	oma 5 Rasi	idanca 8 🗆 Oth	ar (Specify	)
neral neral		'. Menner of Death 1 ⊠Natural 5 □ Panding	28a. Data of In (Month, E	jury ay Year)	28b. Tima of Injury	28c. Inju Wo	ry at ork?	28d. Dascribe	how Injury occur	red	
Attending or death.  actor: Afte by the fune liftcation		2 ☐ Accident invastiga	tion				Yas 2□No				
tal or Attending P rs after death. al Director: After t ed in by the funera Certification:		3 Suicida 6 Could no 4 Homicida datarmin	288. PIRCE OF F	njury - At h atc. (Specil	oma, farm, straat, fy)	factory, offica			Streat and Numb wn, Stata)	ber or Rura	Routa Number
To the Hospital or Attending Physical Particles after death. To the Funeral Director: After this completely filled in by the funeral dimension Medical Certification: To	29	9a. Cartifiar 1 Certifying (Check only one)	Physician: To the best taminer: On the basis and manner:	of axamina	owledga, daath occation and/or invasti	currad at tha ti gation, in my	ma, data and placa opinion, deeth occu	, and dua to tha rred et the time,	causa(s) and modete and place,	annar as stand dua to	ated. the cause(s)
Mithin To the comp		b. Signatura and titla of cartifiar	R	ESIB	ENT	29c. Lican			29d. Data signe	d (Month, I	Day, Year)
->-0		1 EASONGE		PH	YSICIAN	95	7-008		MARCH	4,19	, 1999
		. Nama and addrass of person wh		death (Itar	m 23a) (Type, Prin	t)				- 177	
	f	PATIENCE AGA	30 Johns	Hopki	ns Bayvi	ew Med:	ical Cent	er Ba	ltimore,	, MD	
State	31	. Data filed (Month, Day, Year)		trar's Signa			11111				



State of Maryland / Department of Health and Mental Hygiene 9 9459

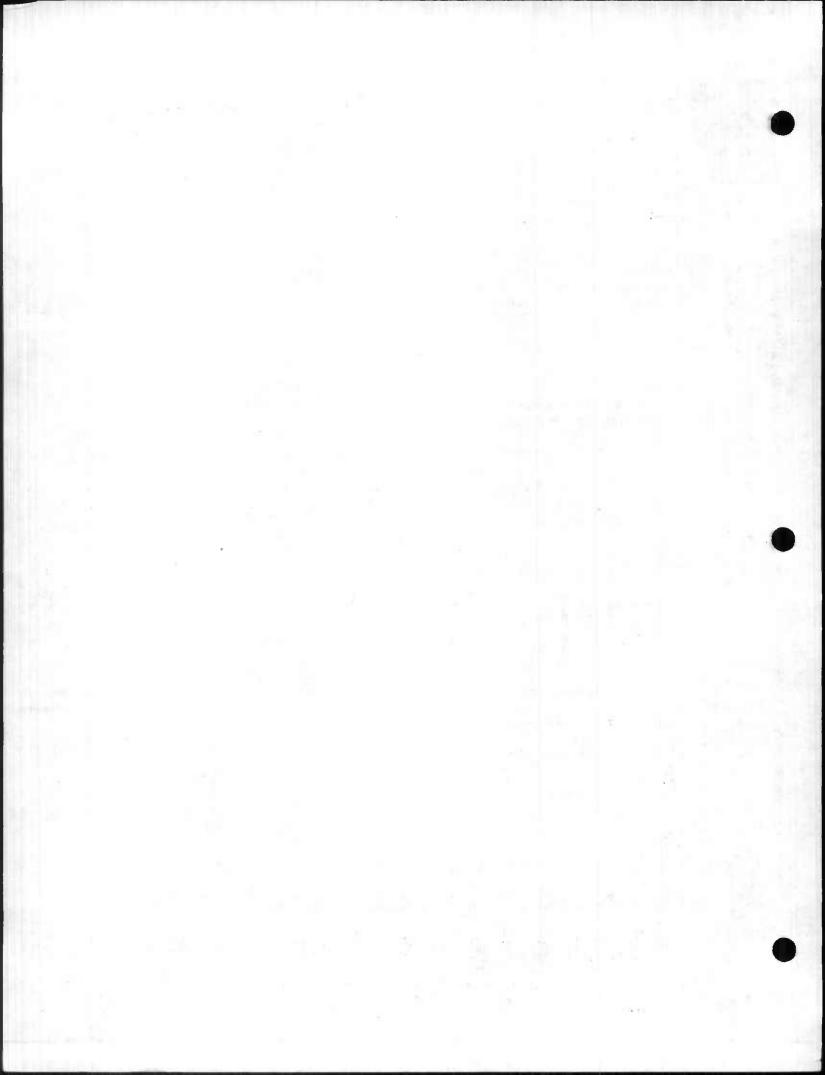
				Cer	tificate of	Death		Reg. No.	0	
	1. Decedent's Nama (First, Mic	ddia, Last)					2. Data of De	eath Day	Vaar	3. Tima of Death
Physician /Medical	Michael Lynn	Adams					Marc		Yaar 1999	1739
Examiner	4a Facility Name (If not Institu		ımber)			4b. City, Town, or	Location of Deat			
	The Memor	ial Hosp	ital			Easton		Talb	ot	
Funeral Director	5. Social Security Number 213-92-5214	6. Sex X□ M 2□ F	7. Aga (In yrs. 37	last birthday) Yrs.	If Undar 1 Year Months Days	If Under 24 Hr. Hours Mir			9. Birthpi Coun Md •	iaca (State or Foraign try)
	Usuai Residenca of Decedent									
if item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Med cal Examiner must be notified at or other traumatic event, the Med cal Examiner must be notified at or other traumatic event, the Med Completed by Funeral Director	10a. State 10b. Cour	nty	10c. Cr	ty, Town or Lo	cation				10	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
oto	Md. Caro	line	Den	ton						
Dir	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Coun	try?
I is	26272 Shore H				21629		0 11 11	U.S.A.	a - Americ	an Indian
by Funeral Director	11. Marital Status  1 Never Married 2 X M  3 Widowad 4 Divorce	Armed F arried 1 ☐ Yes If Yes, G	Z∕ No ive		Yas, specify Cub.	an, Mexicen, Pue	Specify Yes or No rto Rican, atc.)		ck, White, o	etc.
Completed	15. Deced	ent's Education hest grade completed,			ant's Usual Occup		orkin a	16b. Kind of B	usiness/Ind	Justry
pole	Elementery/Secondary (0-12		1-4or 5+)	life. E	O NOT use retire	d)	orning			
00	9			Machin	nest			Paper I		cts
Be	17. Fathar's Name (First, Midd	la, Last)				18. Mother's Ne	eme (First, Middle	, Maiden Suman	10)	
2	Eugene Adams					Karen H	all Adam	S		
	19a. Informant's Name/Relation						Rural Route Numb		State, Zip	Code)
	Tammy W. Adam	s (wife)				wy. Dent	on Md. 2			
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematio	n 3 DRemovai from		Place of Dispos cemetery, crem	sition (Name of patory or other pla	ce)	Date	20c. Location -	City or To	wn, State
	4 Donation 5 Other			reensb	oro Cem.		3-7-99	Greensbo	oro M	d.
Suce.	21. Signature of Funeral Service	CFL.	1	F1e	Nama and Addresses   Nama and	lfenbein	F.H. P.	0.Box 16	50	
ician	23a. art1. Enter the disease, shock, or heart failure. L	or complications that ist only one cause on	caused the dear each line.					arrest,		Approximate Intarval Between Onset and Death
dical niner	Immediate Cause (Final disease or condition resulting In death)	. Su				Herr	nonvi	nase		9 hours
i i			Due to (	or as a conseq	uence of):				1	
e es the burial-transit  Medical Examiner	Sequentially list conditions	<b>b</b>	Due to (	or es e conseq	uence of):					
Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		(	1103.1034	-117-5-77				1	
edical	fugf itiffered executs	C	Due to (d	or as a consequ	uence of):					
Med	resulting in death) Last		,		Y E					
an/N		d								
by Physician/	Part II. Other significant cond	itlons contributing to d	leath but not res	sulting in the ur	derlying cause at	ven in Part I.	23b. Dld	tobacco use co	ntributa to	the cause of death?
Physic	11						10	Yes 200	3 Prot	bably 4 Unknown
be de	Hypert.	eu 5.50	1				-			
should leted								an autopsy ormed?	ave	ere autopsy tindings aliable prior to
nple										mpiation of cause death?
Completed	A SHEET NOTES						10	Yes No	10	Yes 200
BeC	25. Was cese referred to medi	cei				26. Place of D	eath (Check only	one)		
္	examiner?	Hospital:	Inpatiant 2	ER/Outpatien	3□ DOA OH	her: 4 Nursing	Home 5 ☐ Res	Idence 6 Oth	er (Specify	y)
<u>g</u>	27. Manner of Deeth	28e. Dete	of Injury oth, Day Year)	28b. Time of Injury	28c. tnju Wo	ry at rk?	28d. Describe	how Injury occur	red	
atic	L C / tooldont	stigation		,,		Yes 2□No				
Certification:	3 Suicide 6 Cou	mined 200. Flac	e of Injury - At h ling, etc. (Speci	ome, farm, stre	et, factory, office			(Street and Numb wn, State)	er or Rura	il Route Number,
completely filled in by the fune  Medical Certification		ying Physician: To the al Examiner: On the b and mar								
Me	29b. Signature and title of certi	fier			29c. Licans	sa numbar		29d. Data signa	d (Month,	Day, Year)
5	> Denn	is or So	SR	Id,	000	5311	0	3/5/	99	
	30. Name and address of person	C 1 1	se of death (Ital			11.	11 -		- 0	710.1
	Dennis V.	es hiel	d5	Men	nonial	HOSPIT	al Ea	stoy	NU	21601

Registrar



State of Maryland / Department of Health and Mental Hygiene 9 9 0 9 4 6 0

				Ce	ertificate o	of Death	R	eg. No.	03400
		Decedent's Neme (First, Middle, Last)		<b>D</b>	1 1		2. Date of Deat Month	th	3. Tima of Death
	sician ledical	Nellie (NMN	)	Buri	nett		MARCH	04, 199	
	aminer	4a Facility Name (If not institution, give stree				4b. City, Town, or Le	ocation of Death	4c. County of	Death
		THE JOHNS HOPKINS H	OSPITAL			BALTIMORE	CITY		
Fune Direc		5. Social Security Number   6. Sex 197-05-9496   1 □ M   Usuel Residence of Decedent		rs. last birthday Yrs.	Months De		8. Date of Birth (Month, Day, Jan. 21	Year)	9. Birthplece (State or Foreign Country) Pennsylvania
pue a	u	10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
the Maryland	Director	Maryland Harfo	rd	Jopp					1 □ Yas 2 No
ith with	8 0	1042 Erwin Drive			10f. Zip Code	21085			USA
5-0020 72 hours after deanatural", or items	by Funeral	1 Never Merried 2 Merried 1	Vas Decedent Ever in irmed Forces? ☐ Yes 2⊠ No Yes, Giva 'ear or Dates:	U,S. 13.	Wes Decedent of It Yes, specify C	of Hispanic Origin? (Sp suban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)		- American Indien, White, etc. White
5-0 72 ho	Completed	15. Decedent's Education (Specify only highest grade con	n npleted)	16a. Dece	edent's Usuel Oci	cupation ne during most of work tired)	ina	16b. Kind of Busi	
T C 14	omple		college (1-4or 5+)			tired)			turer of
	F O	6		Insi	pector	1.0.10.0		Bottle (	
DO THE HOUSE	Be C	17. Father's Neme (First, Middle, Last) Samuel (nmn) G	erasimoff			18. Mother's Name	e (First, Middle, 1 (nmn)		hkter
should by Mented	10			1					
Maryiand d 2 should be flight th and Mentel Hy 7 Is marked oth	To	19a. Informent's Neme/Reletionship (Type, F Elaine Havrisik - Da				eet and Number or Run Road, Merr			32952
C = 01 1		20a. Method of Disposition			osition (Neme of	· · · · · · · · · · · · · · · · · · ·			ity or Town, Steta
Pege ent c		1 Burial 2 Cremetion 3 Remo	val trom State		emetory or other p Memorial		3/8/99		, Maryland
Baltimo	pncs.	21. Signature of Funeral Service Accepted	mas	2		K. McComas			
		23a./Part1. Enter(the disease, or complication shock, or heart feilure. List only one ca	ns that caused the de	eath. Do not en	131 / CO	kesbury Rd dying, such as cardiac	<ul> <li>Abing or respiretory error</li> </ul>	idon, Mai est,	ryland 21009 Approximete Interval Between
Physici	ian	snock, or near tenure. List only one ca	use on eech line.						Onset and Death
/Medi	cal	Immediate Cause (Final disease or condition	Rotro	100-17	lago.	hana	20 200	0	3 days
Examir		resulting in deeth) a	Due to	(or es a conse	equence ot):	14.0	May	)	3
D 4	iner.		Coas	1000	the				3 Jays
60, be assecuted lician and	Examiner	Sequentially list conditions,		(or es a donse	equence ot)				
58760, cate be asscu		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events							
8 st st	2	that initiated events resulting in death) Last	Dua to	(or as a conse	quence of):				
A 2 0 5		d							
death cer death cer	lan in								
cords, P.O. Box	by Physician/M	Part II. Other significant conditions contribu	ting to death but not n	esulting in the	underlying cause	given in Part I.	23b. Did to		ributa to the cause of death?
D that	F.	Ischemic Car	tomos	athe	1		1)X(Y	●● 2□No 3	3 Probably 4 Unknown
Records, ne law requires to the law requires to the law requires to the law	0.	N 1- 1	01	-	)		24a. Wes a	n autopsy	24b. Were autopsy tindings
000	lete	MORNI Stenos	15				perform	med?	aveilable prior to completion of cause of death?
I Rec	Completed	A-1 Ral	E . le	~				es 2 No	
= F 50	S O	25. Wes case referred to medical	12100	10		00 Di( D	) kil		1 Yes 20 No
	To Be	examiner?	tal: 1 Inpatient 2	□ EP/Outpetic	ent 3 DOA	26. Place of Deat Other:		ence 6 Other	(Snaciki)
Phys Phys	T :C		a. Date of Injury	28b. Tima d		njury at Nork?		w injury occurre	
Vision Attending r death.	atio	1 Neturel 5 Pending investigation	(Month, Day Year)	Injury		Work? □ Yes 2 □ No			
Division or Attending after death. Director: After	artifica	2 Cuinida 6 Could not be	le. Plece of Injury - At building, etc. (Spe		treet, factory, office	се	28f. Location (SI City or Town	reet and Number n, State)	r or Rural Route Number,
DIVISION OF To the Rospital or Attending Phy within 24 hours after death. To the Funeral Director; After this complete limited in the the funeral	edical Certification:	(Check only 2   Medical Examiner: (	r: To the best of my k	nowledge, deel	th occurred at the	e time, date and place, by opinion, death occur	and due to the cred at the time. d	ause(s) end man	ner es stated.
To the P within 24	Med	one)	and manner steted.						
5 ¥ 5 8	3	29b. Signature and little of certifier	A- D	A. A	29C. LICE	ense number	000	A. Date signed	(Month, Day, Year)
1		Charles Ming	- MAC	IN . D		VE2-	440	Marc	1 4 1799
		30. Nama and address of person who comple	ted cause of death (It	tem 23a) (Type	, Print)	14-1	17	本山	0 11
	04-1	31. Dete filed (Month, Day, Year)	3 Registrar's Sig	nature &	CHOK	~ PPIPIR	n long	2 111	- Dortwore
Rea	State istrar	MAR - 0 1999	Disposition of the same	129.	199918				



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 15:03 MARCH Arnold Francis Bevard 8 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fallston General Hospital Fallston Harford If Under 1 Year | if Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 20 M 2□ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours Yrs. 72 218-28-1629 Nov. 15, 1926 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ➡ No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1115 Vale Road USA Funeral 21014 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritei Status 1 Yes 25 No If Yes, Give Year or Dates: 1 Never Married 25 Married 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Air Conditioning 10 Sheet Metal Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Liston Burns Bevard Katherine Dorothy Dalton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma May Bevard/ Wife 1115 Vale Road, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Locetion - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Othe Highview Memorial Gardens3-11-99 Fallston, Maryland 22. Name and Address of Facility HOWard K. McComas III Funeral Home, P.A. 50 W. Broadway Street, Bel Air, Maryland 21014 I, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) · Chronic Obstructive Pulmonary Disease years Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the lattered experience) Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 No 3 Probably 4 Unknown Ischemic Cardiamy opathy. by Severe Osteoporosis with Vertebral Fractures. 24e. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? Completed 1 Yes 2 No 1 Tyes 2 No Be 25. Was cese referred to medical 26. Piece of Death (Check only one) Hospital: 1 Propatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₽ No Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Day Yeer) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ANatural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica stelly filled in by the funeral director, p in 24 hour.
The Funeral Direction of the filled in b

groofd BENAVA

**Funeral** 

Director

r then "netural", or items 23s or 28s-f show the Medical Exampler must be notified at

with the Meryland

death

hours after

permit. Peges 1 and 2 should be filed within: Depertment of Health and Mental hygiene. Important: If Item 27 is marked other than "nany injury or other traumatic event, the Med

**Physician** 

/Medical

Examiner

physician end s the buriel-transit certificate be executed

is certificate hes t director, pege 2 s

altimore.

Registrar

Medical

29a. Certifier (Check only one)

J. Kevin 31. Dete filed (Month, Day, Year) MAR 1 0 1999

29b. Signature end title of certifig

Lynch 32. Pegistrar's Signature

ms

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29c. License number

D350/2

2 North Ave. Belair, md. 21014.

29d. Date signed (Month, Day, Year)

March 9, 1999

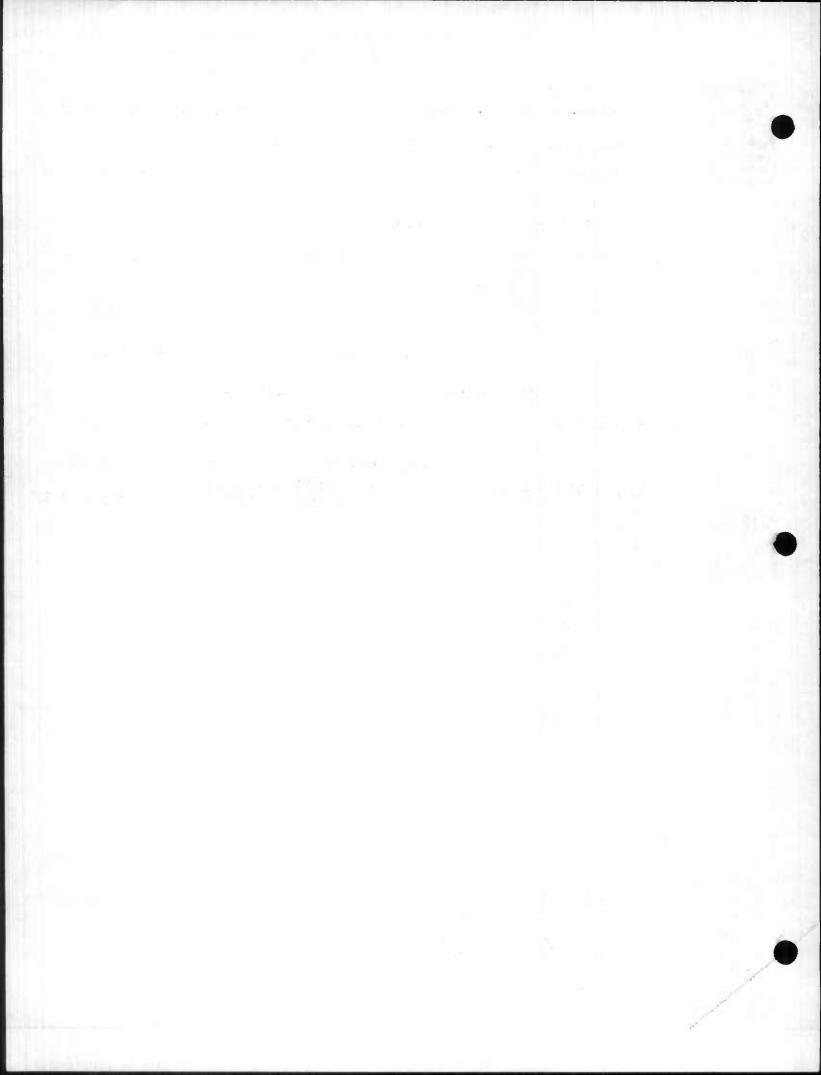
DHMH 16 Rev 6/95

To the Hosp within 24 hor To the Fune completely fi

WAR 18 1999

State of Maryland / Department of Health and Mental Hygiene

					Ce	rtificate	of L	Death		Reg. No.		
	_	1. Decedent's Name (First, Middla,	Last)		100				2. Data of D Month	eath Day	Year	3. Time of Death
Physician /Medical		Marie	Catheri	ne Ber	rnier				March		999	6:43 AM
Examiner	_	la. Facility Nama (If not Institution,					4	b. City, Town, o	or Location of Dea	-		10070
		Shore Nursing a	nd Rehab	ilitati	ion Cer	ter		Dent	on		Caro	line
Funeral			. Sex		s. last birthday	If Under 1		If Under 24 H		irth	9. Births	plece (Steta or Foreig
Director		088-05-8119	1□M 280F		102 Yrs.	Months	Days	Hours Mi	April	30, 1896	Ne	W York
9		Usual Residence of Decedent										
ho ho		10a. State 10b. County		10c. C	City, Town or L	ocation					1	Od. Inside City Limit
o Ma	2	Maryland Carol	ine		Dentor	1						Yes 2 N
or 28s-f si		10e. Street and Number				10f. Zip C	ode			10g. Citizen of	What Cour	ntry?
tied within 72 hours eiter deeth with the Maryland Hydione.  Inter than "natural", or items 23e or 28e-f show  ont, the Medical Examiner must be notified at  a Completed by Funeral Director	2	908 C Edenton	Manor			2	162	.9		Unite	ed St	ates
r items 23a	D	11. Marital Status	12. Was Dec	cedent Ever in I	U,S. 13.	Was Decede	nt of Hi	ispanic Origin?	(Specify Yes or Narto Rican, atc.)		ca - Amaric	can Indian,
T P		1 Never Married 2 Marrie		20 No		1☐Yes 2		Specify:		Specif		ato.
Francisco Francisco I by		3€ Widowed 4 Divorced	Year or			100 94	2110	ороску.		Cau	casia	in
ygiene.  ygiene.  fe than 'natural', or  ft, tra Medical Exam.	20	15. Decadent's (Specify only highest		0	18e. Dece	edent's Usual	Occupa	ation <i>furi</i> ng most of w	vorkina	16b. Kind of B	usiness/in	dustry
.ea.	5	Elementery/Secondery (0-12)		(1-4or 5+)	lita.	DO NOT usa	ratired	)				
t training	5	8			Sale	es Lady	r			Retail		e
d oth		17. Fathar's Name (First, Middla, La	st)					18. Mother's N	lame (First, Middl	e, Maiden Sumen	ne)	
if Health and Mental Hygiene. Item 27 is marked other than "natural, or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at TO Be Completed by Funeral Director	2	Jean Ba	ptiste	Esqueri	re			Heloi	se Cast	teran		
pue s		19a. informant's Name/Relationship	(Type, Print)		19b. Mail	ing Address (	Street	and Number or	Rural Route Num	ber, City or Town,	, Steta, Zip	Code)
Itsm 27 l		Emile L. Bernie	r	Son	2412	20 Asbu	ıry	Drive,	Denton,	Marylan	d 216	529
of He liter		20a. Method of Disposition			Place of Disp cematary, cra	osition (Name matory or oth	of ar plac	e)	Date	20c. Location	- City or To	own, State
nent of h		1 Surial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe			alvary	Cemete	rv		3/9/99	Queens	. New	York
555		21. Signature of Funeral Service Lic	program	1 00				s of Facility	e, P.A.	, accirc,		
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ed by the detached	2	Pert II. Other significant condition	contributing to	death but not re	esulting in the	underlying ceu	ise give	en In Part I.		-/		o the cause of death
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To To		1 ☐ Yes 2 ☐ No	Hospitei: 1	Inpatient 2	☐ ER/Outpatie	ent 3 DOA	Oth	ar: A Nursing	Home 5 ☐ Re	sidence 6 Oth	ner (Speci	fy)
<b>⇒</b> @		27. Manner of Death  1 ☑ Natural 5 ☐ Panding	28a. Date	of Injury onth, Day Year)	28b. Time	of 286	. Injun	y at k?	28d. Describe	how Injury occur	rred	
Ar: Af		2 ☐ Accident invastiga	tion	, , , , , , , , , , , , , , , , , , , ,	,,	М		Yes 2 □ No				
ecto by th		3 Suicide 6 Could no determin	ad 288. Plac	e of Injury - At	home, farm, s	treet, factory,	office			(Straat and Numi	ber or Run	al Routa Number,
al Director: After ted in by the funera	5		Duni	sirig, cto. (opoo	<b>y</b> )					only orally		
within 24 hours ener dear To the Funeral Director: completely filled in by the Medical Certifical		29e. Certifier 1 Certifying	Phyelcian: To th	e best of my kn	nowledge, dee	th occurred at	the tim	ne, date end ple	ice, and due to th	e ceuse(s) end m	enner es s	steted.
within 24 hours effer death.  To the Funeral Director: After completely filled in by the fune Medical Certification	١	(Check only 2 Medical Ex	aminer: On the	hasis of examin	nation and/or li	nvastigation, ir	n my o	pinion, death oc	curred at the time	e, date and placa,	and dua t	o tha ceuse(s)
To the		29b. Signature and title of continue	111	, \	/	29c.	License	e number		29d. Data signe	d (Month,	Day, Year)
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	-	30. Neme and address of person wi	no combined on	ISA Of death (Ite	em 23e) /Tupo	Print)		. / ( -/ 0		/		
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Chata		31. Date filed (Month, Day, Year)	1	Registrar's Sign		,	101	-13-040	1-12 41	000		
State Registrar			200	<b>K</b> .	-							
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month March 04, Day 1999 **Physician** V. Lucy Bennett 11:20a.m. /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Apr. 6, 1910 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M aX F Days Hours 215-32-7572 88 Yrs. Maryland **Director** Usuel Residence of Decedent tha Meryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits I is marked other than "naturel", or items 23a or 28a-f show traumstic event, the Madical Examinat must be notified at 1 ☐ Yes 2 No Directo Leonardtown Maryland St. Mary's 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours eftar daeth with 20650 USA 23765 Hollywood Road Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, Whita, etc. 1 Never Married 2 ☐ Married Specify: Black Maryland 21215-0020 1 Yes 2 No Specify: by 3 AWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade com 16a. Decedant's Usual Occupation 16h Kind of Business/Industry (Give kind of work dona d life. DO NOT use ratired) during most of working College (1-4or 5+) Elemantary/Secondary (0-12) Hygiene. Nursing Center Dietary Aid 18. Mother's Nama (First, Middla, Maidan Sumame) 17. Father's Name (First, Middle, Last) permit. Pegas 1 and 2 should be 1 Department of Health and Mentel I-Important: If them 27 is marked out eny Injury or other traumatic even pince. should be f and Mentel I Jordan Tda Columbus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Leonardtown, MD 20650 23765 Hollywood Road Alice Owens/Daughter Baltimore, 20b. Piece of Disposition (Name of cametary, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Mem. Gardens 3/9/99 4 ☐ Donation 5 ☐ Other (Specify) Greatmills, MD 21. Signature of Funeral Sarvice Licensee 22. Name end Address of Fecility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 9. Deve 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line. Approximata Intervai Batween Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner certificata be executed lcian and buriel-trans Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Cause (Disaasa or injury lhat initiated events resulting in death) Lest physician sthe bunel Box 68760, Physician/Medicai 88 USB thet the death ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the detached signed by t d be detach 1 Yas 2 No 3 Probably 4 Unknown Completed by Records. The law requires 24a. Was an autopsy performed? 24b. Were autopsy findings aveilable prior to should peen s completion of cause of death? has page 2 NA certificata 1 Yes 2 No Division of Vital or Attending Physician: director. 25. Was casa referred to medical Be 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) in 24 hours after death.

the Funeral Director: After this c 1 Yes 2 No 0 1 Depatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred Certification: 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowladga, daath occurred at tha time, date and place, and due to the causa(s) and manner as stated. Medical plataly (Check only one) r: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) within 2
To the I 29b. Signature and title of cartifie 29c. License number 29d. Date signed (Month, Dey, Year)

completed causa of daath (from 23a) (Type, Print)

32. Registrar's Signature

Hollywood, Md. 20636

State Registra

30. Name and add

James P.

31. Date filed (Month, Day, Yaar)

Jarboe

LUCY VIRGINIA BENNE

the committee of the investigation of the contract sets the entropy of the patient and the second

		State of M	arylanu /		tificate			ALICA IVIC		ig. No.		2707
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Examiner	4a Fecility Nama (If not institution, giv	a straat and number)				4	b. City, To	wn, or Loca	ation of Deeth	4c. County	of Death	
	1017 Warwick R	d Apt. 31	В				Aber				ford	
Funeral	Social Security Number     6. S	Sex 7. Ag	ge (In yrs. last L		If Undar 1 Y Months D	aar	If Under Hours	24 Hrs. {	B. Data of Birth (Month, Day,	Year)	9. Birthp	laca (State or Foreign
Director	129-12-16/1	X 20 F	83	Yrs.				J	uly 16,	1915	New	York
pus *	Usual Residence of Decedent  10e. State 10b. County		10c. City, To	wn or Lo	cation	_					1	0d. Insida City Limits
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neturel', or iten ace Example eted by Fun	1 Never Married 2 Married	Armed Forcas? 1 ☐ Yas 2 ☒						, Puerto R	cify Yas or No- lican, etc.)	Bla	ck, White,	etc.
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Important: If item any injury or othe once.	20a. Method of Disposition  1 Burial 200 cremation 3 0	Removal from State	ceme	tery, cren	sition (Name on natory or other	r plac				20c. Location		
reportant: If frem 27 Is marked other than 'in Injury or other treumatic event, the little pace.  To Be Compi	4 Donetion 5 Other (Specif		R.A.F		s & Coi	-	-	3/1	3 W	est Ch	ester	, PA
any in	21. Signature of Funeral Sarvice Licer	nsee			Name and A				al Home	. P.A.		
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edical miner	Immediate Cause (Final disease or condition resulting in deeth)	Θ	1/	vei	umi	21	IA					Caggi
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has be ge 2 sh mpie											of	mpletion of cause death?
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Certification:	4 Homicide determined	200. Pleca of in	jury - At home, tc. (Specify)	iarm, str	eet, rectory, of	HICE		2	City or Town		Jei or Hun	ar / Toute (VulliDel)
To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier 1X Certifying Ph	sysician: To the best	of my knowled	na deett	occurred at #	he tir	ne date en	d place as	nd due to the or	ausa(s) and m	enner se s	stated.
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1	30. Name and address of person who	completed cause of	death (Item 22	) (Type	Print)	-	M	42		1/12	177	
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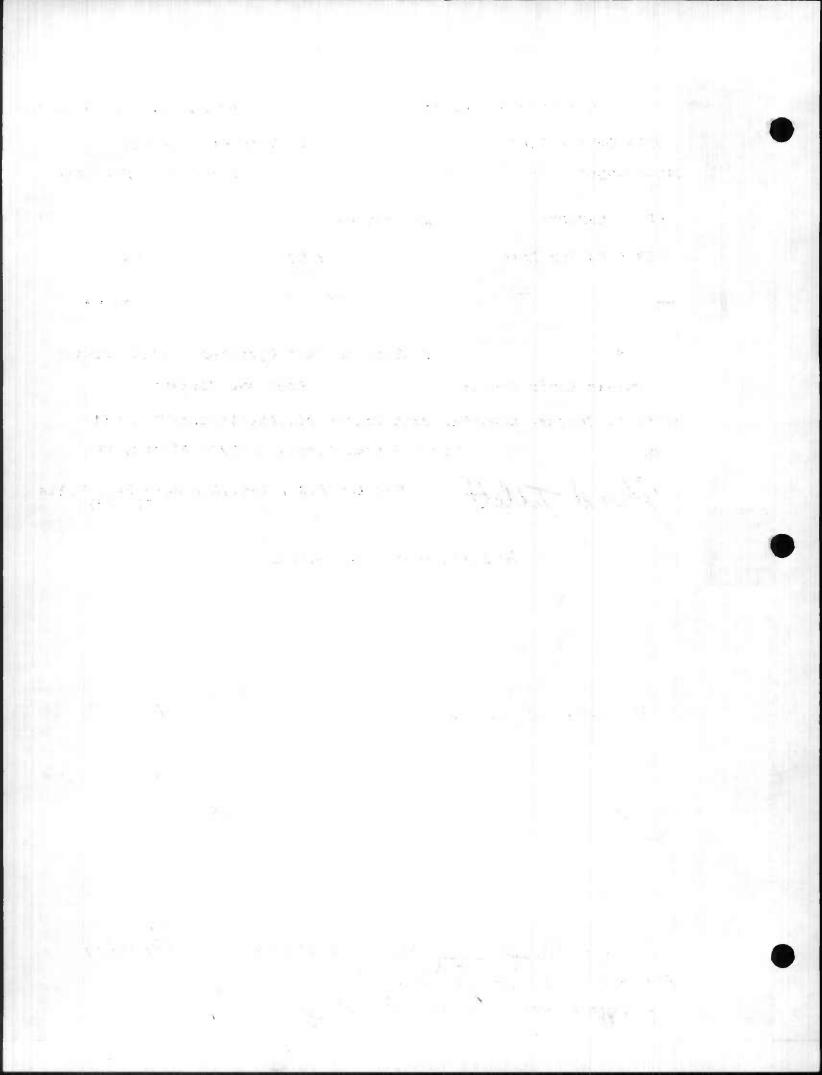
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dele of Death Month Dev Year **Physician** Clifford M. Cooper March 10, 1999 3:00 AM /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Darlington
If Under 24 Hrs. 8. Date of 3314 Dublin Road HArford If Under 1 Months 8. Date of Birth (Month, Dey, Year) Birthpleca (State or Foreign Country) 5. Sociel Security Number 7. Age (In vrs. last birthdev) 8 Sex **Funeral** Days Hours M 20 F 5/19/23 Director 75 Maryland 217-14-7503 Usual Residence of Deceden the Meryland 10c, City, Town or Location 10d. inside City Limits 10e Stete 10b County 7 is marked other than "natural", or itama 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes X No Director Harford Darlington 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number 3314 Dublin Road 21034 Funeral USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces?

Types 2 No 11 Yes, Give . Race - American Indien, Bleck, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health and Mentel Hygiene. Important: If them 27 is marked other than "natural", or item any injury or other traumatic event, the pages. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. White Specify: Completed by ₩Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 Explosives Test Operator Civil Service 18. Mother's Neme (First, Middle, Melden Surneme) 17 Fether's Neme (First, Middle, Last) Be Curvin Louis Cooper Rosa Mae Barrett 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 3314 Dublin Rd., DArlington, MD 21034 Marie A. Cooper- daughter 20b. Placa of Disposition (Neme of Date 20c. Location - City or Town, Stete 20e. Method of Disposition Harford Mem. Gdns., 1 urial 2 Cremation 3 Removel from Stete 4 Donetion 5 Other (Specify) 3/12/99 Aldino, MD 22. Name end Address of Fecility 21. Signeture of Funeral Service Licensee Harkins F.H., Inc., 600 Main St., Delta PA 17314 Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Ceuse (Final ALZHEIMERS disease or condition resulting in deeth) Examiner Due to (or es e consequenca of) Examiner the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): pue Records, P.O. Box 68760 physician Physician/Medical Due to (or es e consequença of) use as ettending Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? the signed by t 1 Yes 2 No 3 Probably 4 Unknown PROSTATE CANCER þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Was en eutopsy performed? Completed peed certificate hes 1 Yes 2 No 1 Yes Division of Vital Attanding Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 2 1 Yes 2 No Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After 1 Neturel 2 Accident 5 Pending investigation To the Hospital or Attanding within 24 hours effer death. To the Funeral Director: Affe completely filled in by the fune 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as steted.

21 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menner stated. 29a. Certifier Medical 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 83 mana 30. Name and address of person who completed cause of digree (Item 23e) (Type, Print) lumtree Rd 2/0/5 32. Registrer's Signeture 31. Dete filed (Month, Day, Yeer)

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 1966

							Cei	tificate	of	Death			Reg. No.		2400
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on	Aftar funa		1 Neturel	5 Pending investigat		nth, Dey Yeer)	Injury	М		rk? ∣Yes 2.∐	No				
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	ne Hospital n 24 hours he Funeral pletaly filled	2	(Check only										ne ceuse(s) end r		
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State Registrar

31. Dete filed (Month, Day, Year)

MAR - 9 1999

brew Newstern

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ANDREW NEWAKONSK! MD (... N. MAIN ST. BEZAIR, MO 21014 32 Registrer's Signeture

D08096

MARCH 7, 1999

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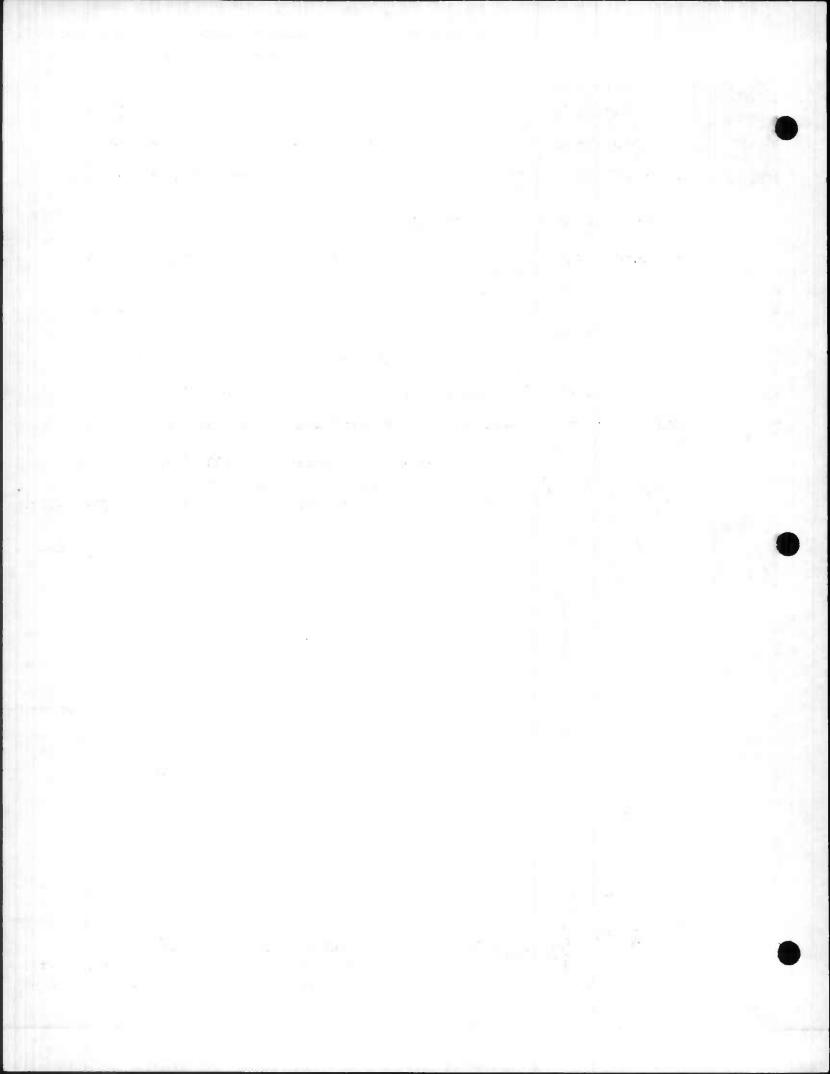
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State of Maryland / Department of Health and Mental Hygiene

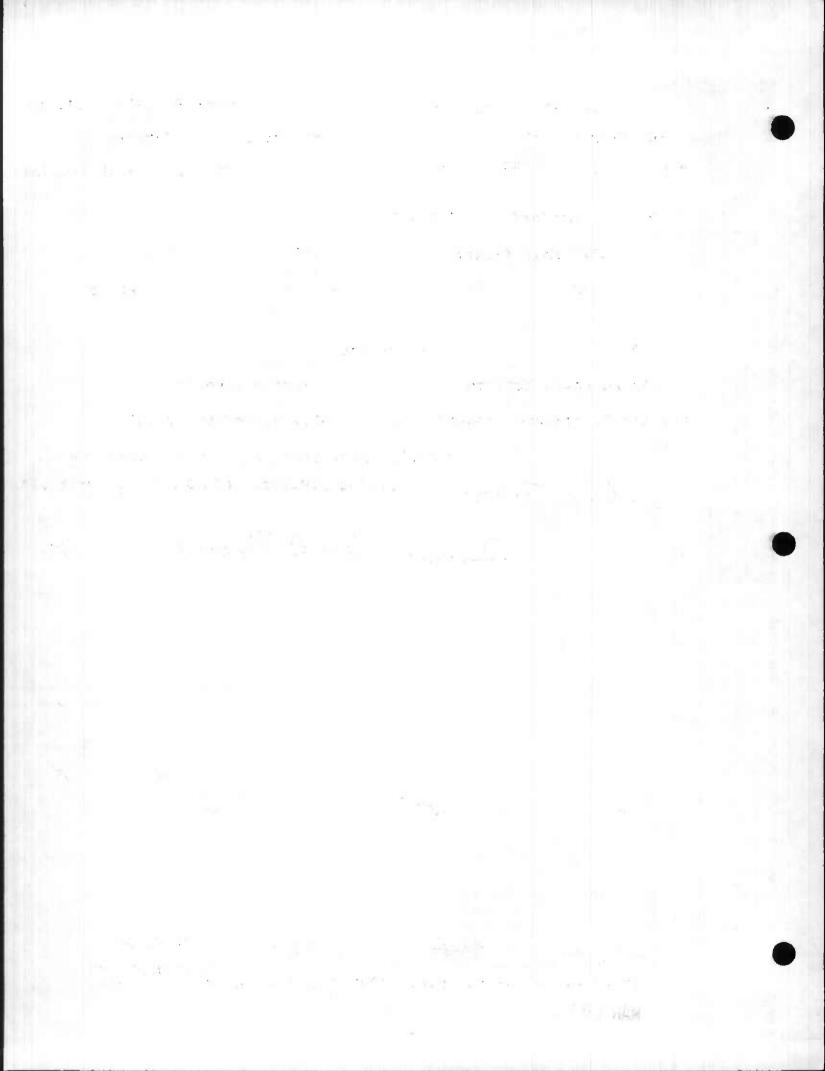
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Director		214-32-0828 Usuel Residence of Decedent	1□M 2√2F	86	Yrs.	Months I	Deys Hours		(Month, Day October 3			ece (Stete or Fo y) / <b>lvania</b>
* m	-	10e. Steta 10b. County		10c. City,	Town or Loca	ation					10	d. inside City L
Pag	to	Maryland Caroli	ne	Rid	gely							1 XYes 2
or 28	i'e	10e. Street and Number				10f. Zip C	ode		1	Og. Citizen of V	Vhet Countr	ry?
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Department of Health Important: If Itam 27 any injury or other tr once.	-	20a. Method of Disposition			ace of Disposi metery, creme			, can	Date	20c. Location -	-	
Department of P Important: If its any injury or of pnce.		1 ☑ Buriel 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spec					emetery	i a	7/99	Centre	ri 110	Marul
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nysician Medical		23a. Part1. Entar tha diseese, or co shock, or heert failure. List on Immediate Cause (Final disease or condition	mplications that caused by ona causa on aech II	the death.	Do not enter	r the mode	th Seconor dying, such as	cardlec o	r respiratory ari	rest,		Approximeta Intervel Betwee Onset end Dee
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State of Maryland / Department of Health and Mental Hygiene

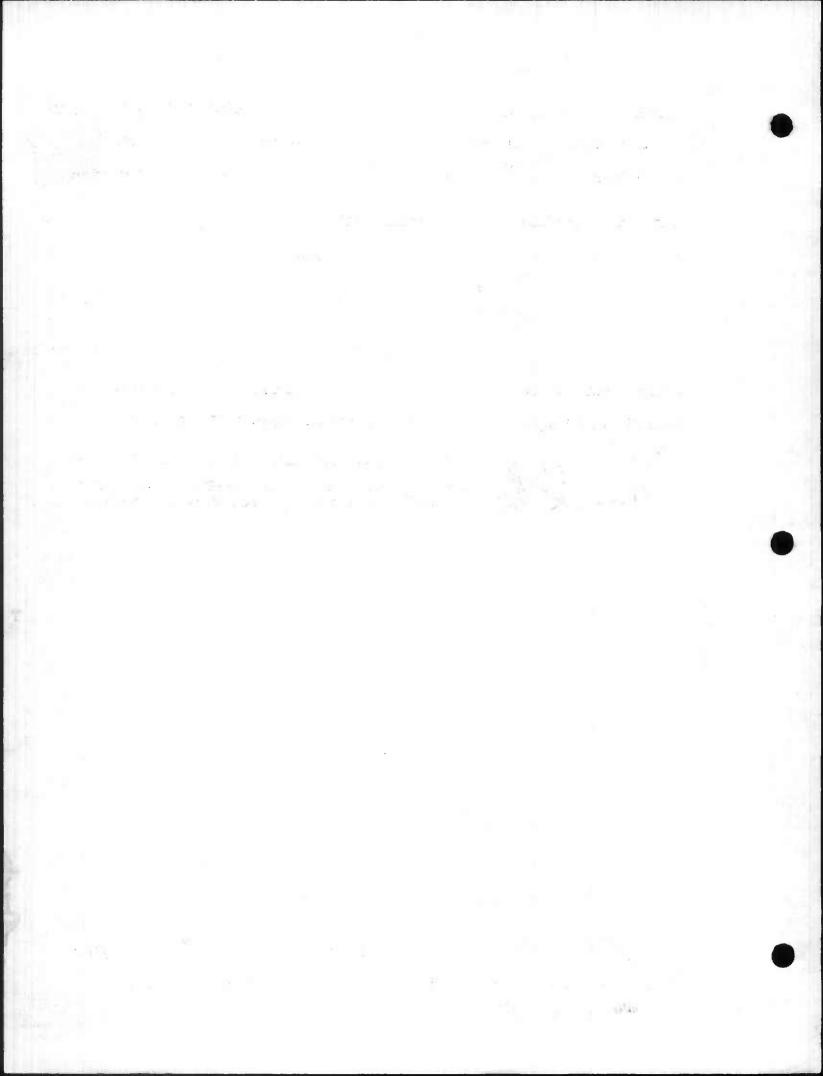
Certificate of Death Reg. No 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month Day Yaai **Physician** 8, March 1999 7:45 AM Lucille. Farley /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1563 Main Street Whiteford Harford If Undar 24 Hrs. Birthpiace (State or Foraign Country) 5. Social Sacurity Number 7. Aga (In vrs. last birthday) If Under 1 Yaar 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours 1 M SONE Months Yrs. 67 Director 215-28-9794 2/29/32 West Virginia Usual Rasidance of Dacedant the Maryland 10c. City. Town or Location 10a Stata 10b. County 10d. Inside City Limits filed within 72 hours after death with the Marylen Hyglens. Wher than "naturel", or items 23s or 28s-f show ent, its descree framine matter notified a XXYas 2 No Whiteford Director Harford 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 21160 1563 Main Street USA Funerai Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Ever in U,S. Armed Forcas? 11 Marital Status 1 ☐ Navar Married 2 ☐ Married □Yas 2**X**Xo Yas, Giva Specif,White altimore, Maryland 21215-0020 1 Yas 2000 Specify: à 3 Widowed 4 Divorced Yaar or Dates. Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highest grade complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Homemaker marked other 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maiden Surnama) permit. Pagas 1 and 2 should be file Department of Haalth and Mental Hy Important: If Item 27 Is marked other any injury or other traumatic event page. Be Blaine David McClure Myrtle Roberts 19b. Mailing Address (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Charles R. Farley- husband 1563 Main St., Whiteford, MD 21160 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramovai from Stata Highview Mem. Gdns 3/11/99 Fallston, MD 4 Donation 5 Other (Specify) 22. Nama and Addrass of Facility 21. Signature of Funeral Service Licensee Harkins F.H.Inc., 600 Main St., D 17314 Delta, PA Enter the diseese, or complications that caused the daeth. Do not antar the moda of dying, such as cardiac or respiretory errest, or haert failura. List only ona causa on each line. Approximate Intarval Batween Onset and Death **Physician** /Medical Immediete Ceuse (Final disaasa or condition rasulting in daath) Examiner Due to (or as a consequence of) Examiner physician and s the bunal-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaase or injury that initiated evants rasulting in daath) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consaquence of) attanding pl the 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. is signed by the 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of causa of death? 24e. Wes en eutopsy performed? Completed peed page 2 s SON NO 2 N No 1 Yes 1 ☐ Yas cartificata To the Hospital or Attending Physician: within 24 hours after death. director, Be 25. Wes case referred to medical 26. Placa of Death (Check only ona) axaminer? Othar: 4 ☐ Nursing Homa 5 🗷 Kesidance 6 ☐ Othar (Specify) 0 1 Yas 2 No 2 A EFVOutpatient 3□ DOA 1 Inpatiant this funaral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Certification: Aftar 5 Panding invastigation 1 Naturel 1 Yas 2 No 2 Accidant within 24 hours after death To the Funeral Director: , complataly filled in by the 3 Suicida 6 Could not be 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 4 Homicide 12 Kertifying Phyeiclan: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to the causa(s) and manner as steted.

2 Medical Examiner: On tha basis of axamination and/or invastigetion, in my opinion, death occurred at the tima, data and place, and dua to the cause(s) end menner steted. edicai 29a. Cartifier (Check only one) 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifiar 3/8/1999 30. Name end eddrass of person who complated cause of deeth (Itam 23e) (Type, Print) Forest Hill, MD Joseph A. Reinhardt, M.D., 2003 Rock Spring Rd., 21050 Registrar's Signature 31. Data filed (Month, Day, Year) State MAR 1 0 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

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	Examir	ner	4a. Facility Name (If not Institution, gi						ity, Town, or Lo	cation of Death	10.000			
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US Vision Attending	after death.  Director: After thi  I in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not b	a	f Injury - At ho	oma tarm	street, fectory,			8f. Location (5	Street and Numb	er or Rura	l Route Nu	mher
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7	within 24 hours after death.  To the Funeral Director: A completely filled in by the fi		29e. Certifier 1 Certifying Pt	yeiclan: To the be	ast of my know	wledge, de	eth occurred et	the time, d	ete and piece, a	nd due to the	cause(s) end ma	nner as str	ated.	
S =	within 24 h To the Fun completely	edical	(Check only 2 Medical Examone)	niner: On the bas and manne	is of examinet	tion end/or	r invastigation, i	n my opinio	n, daath occurre	d at the time,	dete end plece,	and dua to	the causa	(s)
10 th	To the	Σ	29b. Signature end title of certifier	43				License nu			29d. Dete signed			
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	0		30. Name and address of person who	completed cause	11	A	pe, Print)	/ /	52 : Ma	,	1 1	111.	,	
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Baltimore,

**Physician** 

/Medical

**Examiner** 

10a. Stete

Directo

Funeral

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at

**Physician** /Medical

**Examiner** 

Examiner

Physician/Medical

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Completed

Be

Certification:

Medical

State Registrar 29a. Certifier

P.O. Box 68760 Division of Vital Records,

physician and the burial-transit 2 signed I this

Hospital or Attending 24 hours after death.

To the To the To the

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death

1 Naturel 2 Accident 3 Suicide 4 Homicide

6 Could not be determined

28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and placa, end due to the ceuse(s) end manner as stated.

| Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and due to the ceuse(s) end manner as stated.

| Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of Carillian

29c. License number

29d. Date signed (Month, Day, Year) 03-17-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Suite 102, Edgewood, MD1040

From A. R. W.

900 7 F 900

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Le, 1999 3:25 PM DOROTHY HENDERSON MILLER MARCH 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Mariner Health of Bel Air Harford Bel Air If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex 1 M 2 W F 217-22-4174 90 29/1908 Maryland Usuel Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. fnslde Clty Limits 1 Yes 2 No Harford Bel Air Md. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 314 Broadway 21014 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 ANO If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Caucasian 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Harford Board Elementary/Secondary (0-12) College (1-4or 5+) School Teacher of Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Miller James Raymond Emma Keech 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 E. Heather Rd. Marlene H. Daley/Daughter Air, Md. Bel 21014 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3/12 1 Burlal 2 Cremation 3 Removal from State Madonna, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetery 1999 22. Name and Address of Facility & Son Funeral Home, P.A. 21. Signature of Funeral Servica Licensee 711 Jarrettsville, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live. Approximate Intervat Between Onset and Death tmmediate Cause (Final diseese or condition resulting in death) di pulmanary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings avaitable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ NO Yulmo nory ONIC 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nuseing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28c. Injury at Work? 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

/Medical Examiner and P.0. # After after death Director: 0 A 24 horard D To the Within 2

Completed Be 2 Certification: Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than 1

permit. Pages Department of Important: If it any injury or o

**Physician** 

Director

Funeral

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Be

Physician/Medical

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the Maryland

State Registrar

MANUEL 31. Date filed (Month, Day, Year) MAR 1 0 1999

LXZXTL 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated.

29d. Date signed (Month, Day, Year)

Abendeer, Maryland

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Marie Land				ertificate of	Death		g. No. 99	09472	
Dhusinian	1. Decedent's Name (First, Middle, Las	2. Deta of Death Month		3. Tima of Death					
Physician /Medical	Doris Valerie	Lighthise	March 7	. 1999	2340				
Examiner	4e Facility Name (If not Institution, giva				4b. City, Town, or L	ocation of Deeth	4c. County of	of Deeth	
(Q)	Harford Memorial	Hospital		Figure	Haure d	e Grace	Harf	ord	
Funeral	5. Sociel Security Number 6. Se		yrs. last birthda	y) If Under 1 Year		8. Dete of Birth (Month, Day,		Birthplace (State or Fore Country)	
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th with the Maryla 23e or 28e-f shor at be notified at al Director	Maryland Harfo	ord	Street						
or 2	10e. Street and Number			10f. Zip Code		to	og. Citizen of W	het Country?	
2 44 100	4515 Rosemary's Wa	ay .		2115	54		US	A	
ner death v r Herre 23e siner.mast.	11. Marital Status	12. Was Decedent Evan Armed Forcas?	r in U,S. 1	3. Wes Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-		- American Indien,	
urs after ur, or he Examine by Fu	1 ☐ Never Merried 2 ☐ Marrled 3 € Widowed 4 ☐ Divorced	1 Yas 2 No If Yes, Give Year or Detes:		1 ☐ Yes 2½ No		noan, etc.,	White, etc. White		
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Pag ment: uny	4 ☐ Donetion 5 ☐ Other (Specify,		Morelan	d Memoria	l Park 3	-10-99	Baltimo	re, Maryland	
permit. Pages I ar Department of Heal Important: If them 2 any injury or other once.	21. Signature of Fureral Service Licens	see /			ess of Facility McComas				
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cartificate irector, pag	25. Was care referred to medical	/			26. Place of Dear	th (Check only one	a)		
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Physic ruthis aral di	27. Maryher of Death	28a. Date of Injury (Month, Day Ye		of 28c. Inju		28d. Describe ho	-		
Aftar Attar funar funar	NZNatural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day Ye	ar) injun		ork? ☐Yes 2☐No				
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after Directif	4 Homicide determined	building, etc. (S)	pecity)	stroot, ractory, critice		City or Town,			
To the Hospital or Atlanding Ph within 24 hours after death. To the Funeral Director: After th complately filled in by the funeral Medical Certification: 1	SON CONTROL MAN ON A STATE OF								
Hospital 24 hours Funeral stely filled	(Check only 2 Medical Exami	sician: To the best of my ner: On the basis of exa	y knowledge, de minetion and/or	ath occurred at the t investigation, in my	ime, date end place, opinion, death occur	and due to the ce red et tha time, da	euse(s) end mer ata and place, a	nner es stated.  nd due to the ceusa(s)	
Hin 2	one)	and menner steted.		1					
T V To	29b. Signature and title of certifier	11 1		29c. Liper	ise number	29	Dale signed	(Month, Day, Year)	
	X115111) 41	N W		1	404		71819		
1	30. Neme and addrass of person who o	ompleted causa of death	(Item 23a) (Typ	e, Print)	Min	n /	1 0	11/h 11-76	
2	31. Date filed (Nonth, Day, Year)	79 S	Mon	DIP	riple	1/6 PM	1816	MII) 7/10	
State	MAR - 9 1999	They street s	Jan Land	1	,				

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	Certificate of Death		Reg. No.	09470						
Physician	1. Decedent's Neme (First, Middle, Last) Lidia G. Lacey	2. Dete of Dee Month	eth Dey	3. Time of Deeth						
/Medical Examiner		, or Location of Death								
Funeral	ILIM ZIJE	Hrs. 8. Date of Birt Min. (Month, Day	h y, Yaer)	e George's  9. Birthplaca (State or Foreign Country)						
Director	145   32   8207	March .	15, 1937	шша						
Maryland of show fed at	10e. Stete 10b. County 10c. City, Town or Location  MD Charles Hughesville			10d. Inside City Limits 1 ☐ Yes 2 ☐ No						
with the Mar a or 28a-f at De notified	10e. Street and Number 6139 Trotters Glenn Drive		10g. Citizen of Wh	nat Country?						
n 23	20637  11. Marital Status  12. Was Decedant Evar In U.S.  13. Wes Decedent of Hispenic Origin	7 (Specify Yes or No-	United States  Office Yes or No- 14. Raca - American III							
within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-f show ha Medical Evaninar must be notified at homeleted by Filmaral Director	3 ☐ Wildowed 4 ☐ Divorced Yeer or Detes:	uerto Rican, atc.)	Specify:	White, etc. White						
ed within 72 ho ygiene. Ner than "netur it, the Medical.	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondery (0-12)  College (1-4or 5+)	working	orking 16b. Kind of Business.							
d with	10 Secretary		Business	s Office						
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should be and Ment marked umartice	Gregory Ivanoff Ver	a Dubrowsl								
2 4 5	19e. Informent's Name/Reletionship (Type, Print)  Frederick V. Lacey (HUSBAND)  19b. Meiling Address (Street end Number of 6139 Trotters Glenn									
SEE	20b. Mathod of Disposition  ABBurial 2 Cremetion 3 Removal from State  4 Donetion 5 Other (Specify)  20b. Place of Disposition (Neme of cemetery, cremetory or other place)  Maryland Veterans Cemetery  Cheltenhar									
permit. Page Department of Important: If any Injury or ance.	21. Signature of the Address of Fecilities  Alexandria Ferry									
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as caused the deeth. Do not enter the mode of dying and caused the deeth. Do not enter the mode of dying and caused the deeth. Do not enter the mode of dying and caused the deeth. Do not enter the mode of dying and caused the deeth. Do not enter the mode of dying and caused the deeth. Do not enter the mode of dying and caused the deeth. Do not enter the mode of dying and caused the deeth. Do not enter the mode of dying and caused the deeth. Do not enter the mode of dying and caused the deeth. Do not enter the mode of dying and caused the deeth. Do not enter the mode of dying and caused the deeth. Do not enter the mode of dying and caused the deeth. Do not enter the mode of dying and caused the deeth. Do not enter the deeth. Do not enter the deeth. Do not enter the dying and caused the deeth. Do not enter the dying and caused	rdiac or respiratory a	rrest,	Approximete Intervel Between Onsat and Death						
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- 42	Pert til. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Pert I.									
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The law ate has page 2		1/2	Yes 2 No	1⊠Yes 2□ No						
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or Attending after death.  Director: After din by the fune fune ertification	27. Manner of Deeth  1 Naturel  2 Accident  3 Suicide  4 Homlcide  28. Dete of Injury  (Month, Dey Year)  28. Time of Injury  (Month, Dey Year)  28. Time of Injury  28. Injury et Work?  1 Yes 2 No  28. Plece of Injury At home, farm, street, factory, office	Autom 281. Location (S City or Tov		accident ror Ayral Route Number, 0) Brandy wine						
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end position of the properties of th	lece, and due to the	cause(s) and man	ner es stated.						
within 2 To the comple	29b. Signeture end title of cartifier 29c. License number		29d. Date signed	(Month, Dey, Year)						
->-0	Stysh & Made, ND O.C.M.E.		March 02	1999						
12	30. Neme end eddréss of person who completed cause of deeth (Hem 23e) (Type, Print)  Stephen S. Radentz, 111 Penn Street, Ba	altimore,	Maryland	21201						
State Registrar	31. Date filed (Month, Marker) 5 199932. Registrar's Signeture									

# Calvin Mcglothin Maryland

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2 0553 March 1999 Calvin Eugene McGlothin /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Memorial Hospital Talbot Easton If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Days Hours Months 10XM 2□ F 223-38-9837 Director 65 October 19, 1933 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Majoral Existent must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Caroline Denton 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? Funeral 620 Camp Road 21629 United States Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U.S. 11. Meritel Stetus 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Caucasian py 3 Widowed 4 Divorced Year or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Hyglene. 12 should be filed w h end Mental Hygler 7 la marked other th 8 Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Ruth Moore Robert McGlothin 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2:
Department of Health er
Important: If Item 27 la
any injury or other trau Kimberly Meadows Daughter 201 Garden Courts, Federalsburg, Maryland 21632 altimore. 20b. Place of Disposition (Neme of cemetery, crematory or other piece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Denton Cemetery 3/7/99 Denton, Maryland 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Moore Funeral Home, P.A. 10012 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel Acute Myocardial Infarction 1 day disease or condition resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Lest pue -trar Due to (or es a consequence of): physician e 8 Physician/Medical Due to (or as a consequence of): attending 5 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? the 1 Yes 2 No 3 Probably 4 Unknown à COPD pengis d pe det by law requires 24b. Were eutopsy findings available prior to 24a. Wes en autopsy performed? Completed peen completion of cause of deeth? has 1 Yes 2 No 1 Yes 2 No After this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2X No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: Attending 1 XNatural 5 Pending Investigation deeth. 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours efter deeth. To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the csuse(s) and manner stated. edical 29a. Certifier 29d. Date signed (Month, Dey, Yeer) 29c. License number 29b. Signeture and title of certifi-

D32036

M.D., 2108 Red Apple Plaza, Chester, Maryland 21619

March 2, 1999

State Registrar

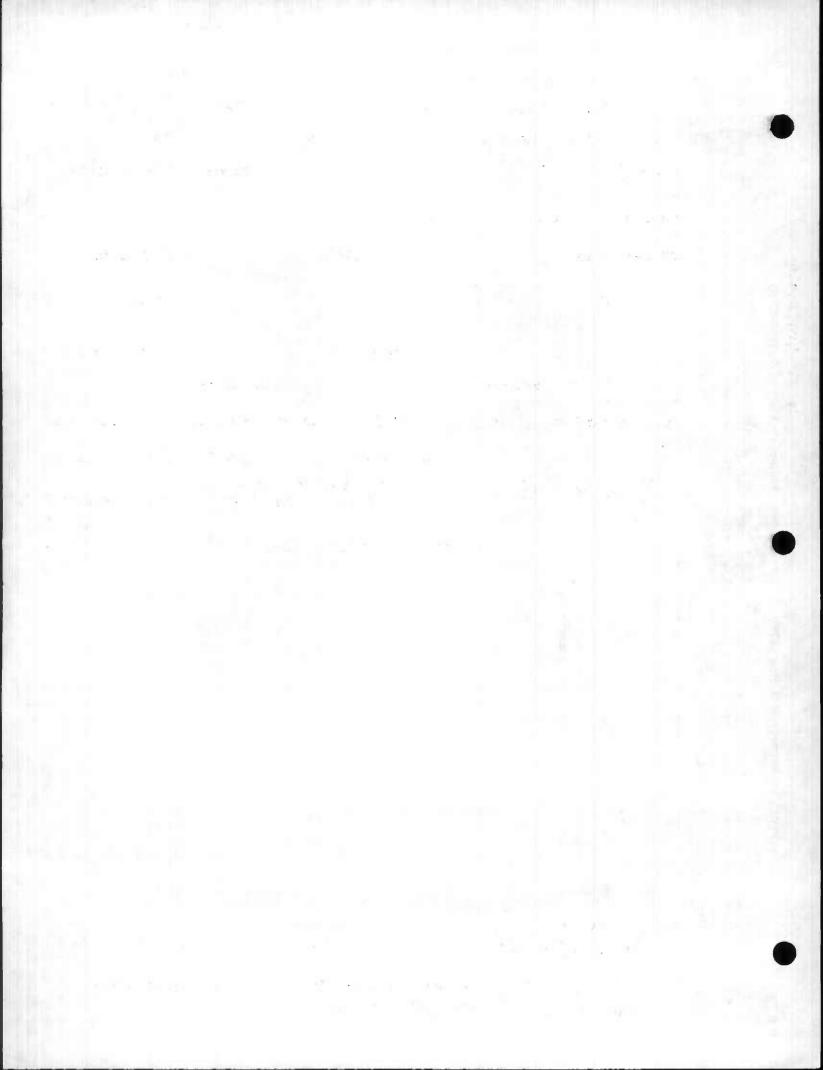
30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

32 Registrer's Signature

provie

31. Dete filed (Month, Dey, Year)

MAR 0 5 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

March

4b. City, Town, or Location of Death

Day

5

Year

1999

4c. County of Deeth

3. Time of Death

2125

Physician	
/Medical	
Examiner	

4a. Fecility Name (If not Institution, give street end number)

1. Decedent's Name (First, Middle, Last)

Bowdle

Marker

Mildred

**Funeral Director** 

the Marylend 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Madical Examiner must be notified at 72 hours efter 1 and 2 should be filed within 7 Health end Mental Hygiene. om 27 Is merked other than \*r

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

permit. Pages 1 and 2.
Depertment of Health el
Important: if item 27 is
any injury or other treu

that the death certificate be executed and physician ar attending p ed by the a signed t peen has page 2 certificate To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

P.O. Box 68760,

Records.

Division of Vital

Talbot The Memorial Hospital Easton If Under 1 Yeer If Under 24 Hrs.

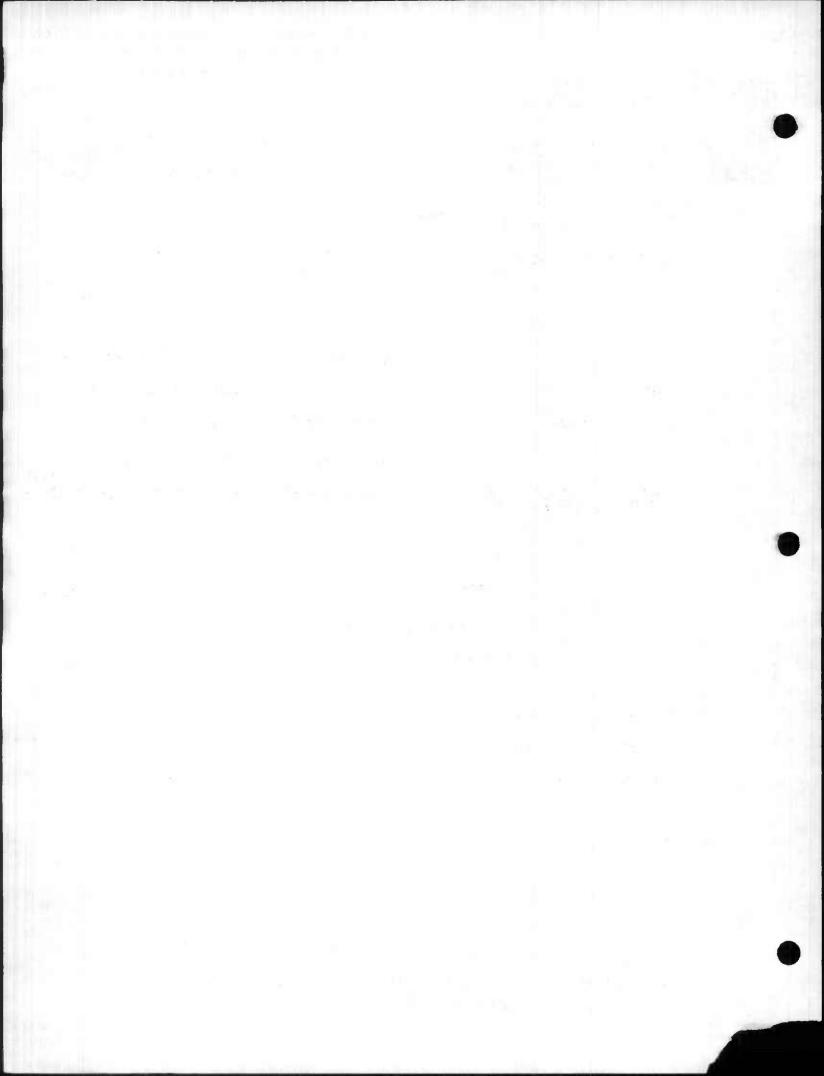
Months Days Hours Min. 8. Date of Birth (Month, Dey, 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Months 1 M 2 TF 222-05-6167 Yrs 91 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Kent Dover 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19904 USA 122 S. Bradford Street Funeral 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Dress Shop 12 Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Belle (maiden surname unknown) 2 Elmer Bowdle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 61 S. Turnberry Dr., Dover, De. 19904 Mary Elyn Massey 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/9/99 Templeville, Md Templeville Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility De 19904 Torbert Funeral Chapel, 61 S. Bradford St., Dover 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 - 5 - 99urosepsis Due to (or as e consequence of): Examiner hypotension 3-5-99 Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): 3-5-99 acute myocardial infarction Physician/Medical cardiomyopathy vears Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown h/o sick sinus syndrome ò 24e. Wes an autopsy performed? 24b. Were eutopsy findings aveilable prior to completion of ceuse of death? Completed congestive heart failure 1 ☐ Yes 2/3/No diabetes mellitus 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medicel examiner? 26. Place of Death (Check only one) Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3-6-99D47627 30. Name and address of person who completed ceusical deeth (Item 23e) (Type, Print) Kathleen Hoey, M.D. 2540 Centreville Rd., Centreville, Md. 21617

books

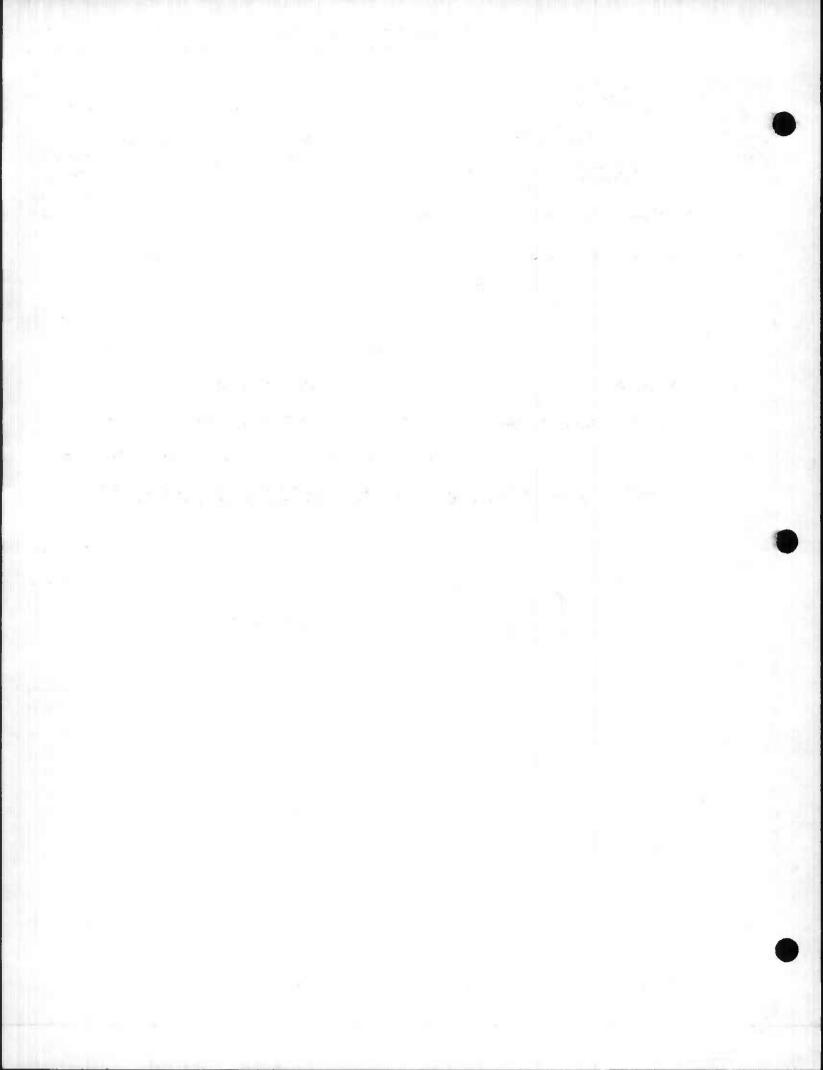
State Registrar

31. Date filed (Month, Day) (87) 1999

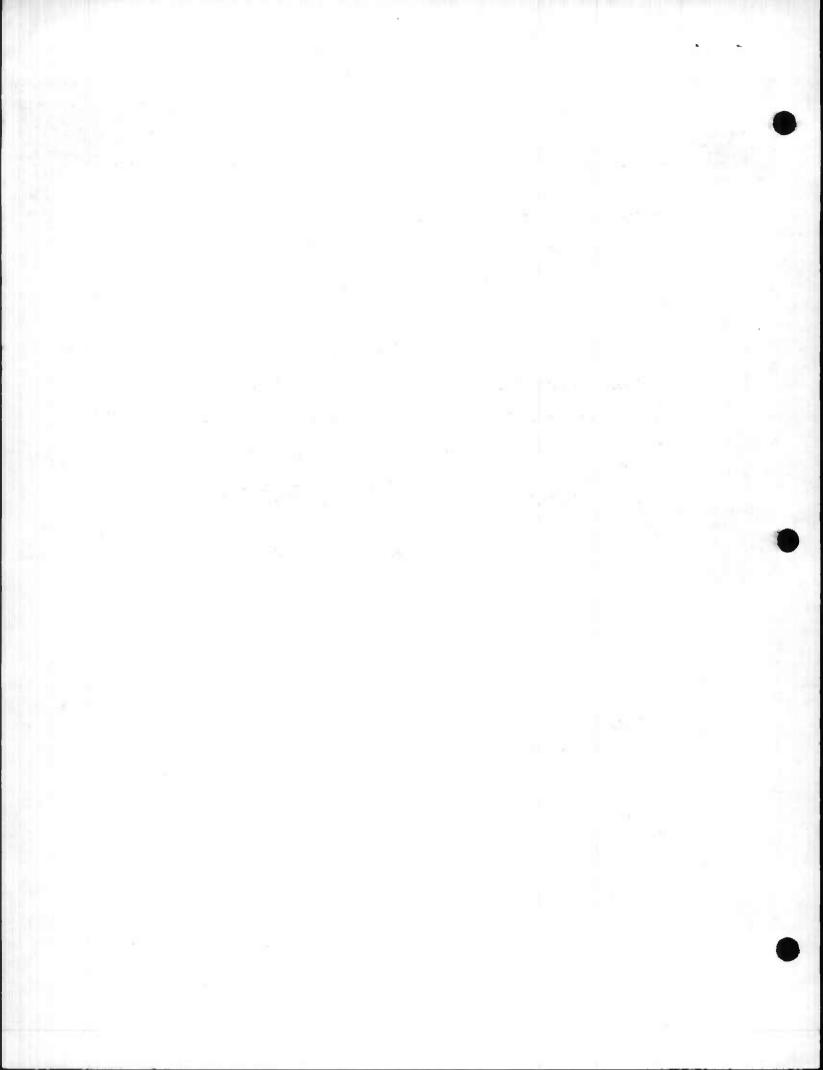


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath Month 3. Tima of Death **Physician** Yaar Annie Moore 27 1999 Feb 8:55 A /Medical 4a. Facility Nama (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner 4c. County of Death Shore Nursing & Rehab Center Denton Caroline If Undar 1 Yaar 5. Social Sacurity Number if Undar 24 Hrs. 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthpiaca (State or Foreign Country) **Funeral** 1 □ M 2 1 F Days 217-36-0599 Yrs. Director 96 Nov. 29 1902 | Virginia Usual Rasidance of Dacedani the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or itams 23a or 28a-f show traumetic event, the Medical Examiner mast be notified at Maryland Caroline Ridgely 1 ☐ Yas 2 ☑ No Director 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 22055 Sawmill Road 21660 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amarlcen Indian, Black, Whita, atc. 72 hours aftar 1 Yas 2 No if Yas, Giva Yaar or Datas: 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: by 3 X Widowed 4 ☐ Divorced White Completed 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. KInd of Businass/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important; if Item 27 is merked other than any injury or other traumetic event Elamantary/Secondary (0-12) Collaga (1-4or 5+) 8yrs homemaker own home 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Henry Wise Mary Shank Wise 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Ruth M. Segar/ daughter P.O. Box 14 Hillsboro, Maryland 21641 20a. Mathod of Disposition 20b. Place of Disposition (Name of camatary, crematory or other place) Data 20c. Location - City or Town, Stata 1 Buriai 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) Denton Cemetery 3/2 Denton, Maryland 21. Signatura of Funaral Sarvice Licansas 22. Nama and Addrass of Facility Fleegle & Helfenbein Funeral Home, P.A. 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarvai Batween Onsat and Death **Physician** Saps1) /Medical Immadiata Causa (Final disaasa or condition rasulting in daath) Y days Examiner Dua to (or as a consequance of): Examiner Cerebro vosculor 2 mon 14, the attending physician and hed for use as the burial-transit requires that the death certificate be executed Dua to (or as a consequence of): Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury 5 Jears heart Coryestive Box 68760. Physician/Medical that initiated avants Dua to (or as a consequence of): rasuiting In daath) Last P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Division of Vital Records, by 24b. Wara autopsy findings available prior to completion of ceusa of death? Completed 24a. Was an autopsy paga 2 s 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No 25. Was cesa rafarrad to madical axaminar? Be 26. Placa of Daath (Chack only ona) Hospitai: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 10 1 Yas 2 No To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral uneral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 ☐ Sulcida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 | Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medical (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number MO chase 3/2/91 DOO 5113Z 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) Abrego 31. Date liad (Month, Day, Year) lattin La Denton 32. Ragistrar's Signatura State Registrar MAR 0 3 1999



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McDade	State of Maryland / Department of He	ealth and Mental Hygiene	18
#23 PART I, 27,	28A-F PER MEO G769 3-24-99 Certificate of D	Death Reg. No.	

ITEMS
Physician /Medical Examiner
Funeral Director
70

permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Merylen Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature!; or items 23a or 28e-f show any Injury or other traumatic event, the Mexical Examinat must be notified at an any Injury or other traumatic event, the Mexical Examinat must be notified at an any Injury or other traumatic event, the Mexical Examinat must be notified at an angle and any Injury or other traumatic event.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the bunel-transit

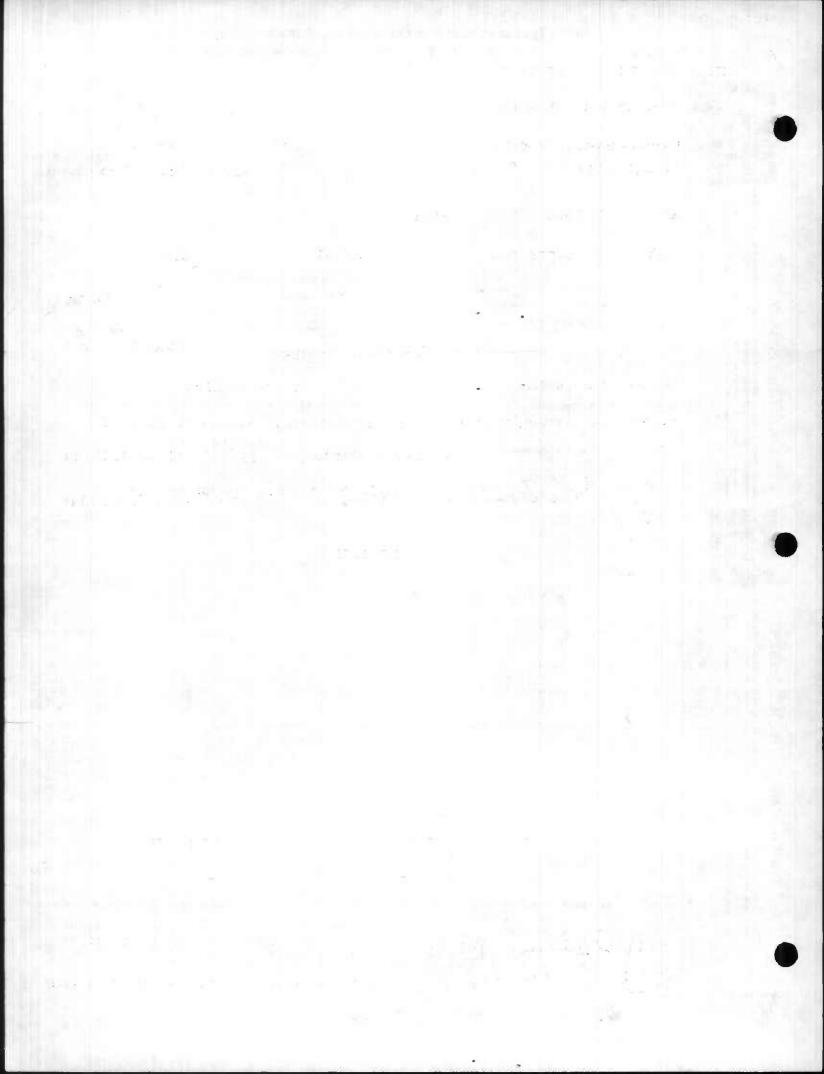
Division of Vital Records, P.O. Box 68760,

1. Decedant'a Nama	(First, Middla, Las	st)							2. Data of De		W. II.	3. Tima of Death
Stefan	ie R. Mo	cDade							March	Day 12, 1990	Yaar	6:00 A M
4a Facility Nama (If	not institution, give	a street and number)					4b. City, To	wn, or L	ocation of Daath			
Easton Me	emorial H	lospital					Eas If Undar	ston		Talbo	ot	
5. Social Security No	umber 6. Si	ax 7. Age	a (In yrs. la:		If Undar 1 Months	Yaar Days	if Undar Hours	24 Hrs. Min.	8. Data of Bird (Month, Da	th V Veer)	9. Birti	hplace (Stata or Foraign untry)
176-62-	3334	3	1	Yrs.					April 2	, 1967	Pen	nsylvania
Uaual Rasidenca of 10a. Stata	10b. County		10c. City,	Town or Loc	cation	_						10d. Insida City Limits
MD	Talbot		Ea	ston								1 ☐ Yaa ZX No
10e. Street and Num	nber				10f. Zip 0	Coda				10g. Citizan of \	What Co	untry?
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3 Widowed	4 💢 Divorced	If Yas, Giva Yaar or Datas:		1	Yes 2	XI No	Specify:			Specify	/: W	hite
/Snaci	15. Decedant's Ed	lucation de completed)		16a. Daced	ant's Usual	Occup	ation	t of work	kina	16b. Kind of B	usinass/l	Industry
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19a. Informant's Na									ral Routa Numb			
20e. Mathod of Disp		ide/fathe		to 5 5 ca of Dispos			a Ave		Hanove	r, PA		
1 X Burial 2		Ramoval from Stata	car	endre	natory or off	ar pla	ery	Mai	rch 16,	White		
21. Signature of Far	Hiral Service Ucen	100/			. Nama and							
1	* Ha	renste	in	2	4 Sec	art	enst	ein	Mortu New Fre	ary, I	nc.	17349
23a. Party Enter	e disaasa, or comp	olleations that causad	tha daath.	Do not anta	ar tha moda	of dyir	ng, such as	cardiac	or raspiratory a	rrast,		Approximata Intarval Batween
7	Tallura. List Orlly	ona cause on agon in	Id.									Onset and Death
Immadiete Cause (I disaasa or condition	Final			DRUG IN	TOXICA	TION						
rasulting In daath)		a	Dua to (or	as a consequ	uance of):							
Sequentially list con	nditions,	D	Dua to (or a	as a consequ	uance of):							
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thet initieted avents rasulting in daeth) L			Dua to (or a	s a consequ	uanca of):							
		d										
Part II. Other signific	cant conditions co	ontributing to death be	ut not rasult	ing in tha un	ndarlying ca	usa giv	an in Part I		23b. Did	tobacco uae co	ntribute	to the cause of death?
									1 🗆	Yes 2 No	3 🗆 Pr	robably 4 Unknown
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										an autopsy med?	1	avallable prior to complation of causa
											(	of death?
									1 🗷	Yas 2□No		1 ■Yas 2□ No
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1 XYas 2 1	40	Hospital: 1 Inpatia		R/Outpatient		,		irsing H	oma 5 Rasi			city)
27. Mannar of Death 1 ☐ Natural	5 Pending	28a. Data of Injur (Month, Day	y Year)	8b. Tima of Injury		c. Injui	ry at rk? Yes 2 🖔	No		how injury occur		
2 ☐ Accidant 3 🖄 Suicida	investigation	3-1	2-99		:55 <sup>M</sup>		Yes 2M	NO		INGESTED		
4 Homicide	datarminad	28a. Plece of Inju- building, ato				office			City or To	wn, Stata) 226	-A S	AURORA ST.,
29a. Certifier	1 Cardibutan Di	veloten. To the base		ND AT H		dla a'	ma det -	d ela-	EASTON	-	00000	etated
(Check only one)	2 Medical Exam	ystctan: To the best of iner: On the basis of and mannar sta	examinetic	edge, deeth on and/or inv	astigetion, i	n my c	me, dete en pinlon, daa	th occur	, end due to the rred at tha time,	dete and plece,	end dua	s stated. I to the ceuse(s)
29b. Signatura and t	title of certifiar		20		29c.	Licans	a number			29d. Data signe	d (Monti	h, Day, Year)
1	Perta	ner 1	1-11	1			O.C.	M.E	•	March	13,	1999
30. Neme and addra	iss of person who o	complated cause of d	eath (Item 2	23a) (Type, F	Print)				4			O DEFEND
TORK	ph (	0	res			Per	n Str	cet:	, Baltin	nore. Ma	arvla	and 21201

State Registrar 31. Data filad (Month, Day, Year)

3

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

				- Jane				Death		Reg. No.	U	94/	9
Physician	_	. Decedent's Name (First, Middle, Las							2. Dete of De Month	Dey	Yeer	3. Time o	
/Medica	ı L	Anne Catherine N							March		99	6:20	A.M.
Examine	r 4	e Facility Name (If not institution, give						4b. City, Town, or		,		1	
	٠,	Mariner Health o				H I lock	er 1 Yeer	Forest If Under 24 Hrs			rfor		-
Funeral Director		. Social Security Number 6. S 078–18–2862 1	ex □M 2€F 7. Age	74	est birthday) Yrs.	Months		Hours Min.		7, 1924 I	Cour	place (Stete htry) YOTK	or Foreign
pun Man		Oa. Stete 10b. County		10c. City	, Town or Loc	cation					1	Od. Inside C	City Limits
Mary	ō	Maryland Harford	1	В	el Air							1 Yes	s 2 No
d 21215-0020  Glied within 72 hours after death with the Maryland Hygiene.  they than "catural", or fterna 23a or 28a-f show int, the Madical Experience must be notified at	5	0e. Street and Number 215 Richardson	Street		91	10f. Z	ip Code	21014		10g. Citizen of W USA		itry?	
dea	Lunera	1. Marital Stetus	12. Was Decedent E	Vas Decedent Ever in U,S.  13. Wes Decedent of Hispanic O If Yes, specify Cuban, Mexica			lispanic Origin? (S	Specify Yes or No	- 14. Reca	- Americ	an Indian,		
21215-0020 d within 72 hours effer piene. Ir then "neturel", or fit in Medical Example.	2	1 ☐ Never Merried 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo			2 No	Specify:	to riour, otc.,	Specify:		ite	
5-0 72 ho	9	15. Decedent's Ed (Specify only highest gra	lucation		16a. Deced	ent's Us	ual Occup	eation during most of wo	rkina	16b. Kind of Bus	siness/Inc	dustry	
2121 3 within gione. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	'life. D	O NOT	use retire	Stationery					
d 212 filed withi Hygiene. other than ant, the te	5	6			Secr	etar	У	40.50.00	450		-		
2 8 E 5 9	ם י	<ol> <li>Fether's Neme (First, Middle, Last)</li> <li>(Unknown)</li> </ol>							nown)	Meiden Sumeme	9)		
Should Man	-  -	19e. Informent's Neme/Reletionship (1	Type, Print)		19b. Meilin	a Addres	ss (Street	end Number or R	ural Route Numb	er, City or Town, S	State, Zio	Code)	
CENL	16	Maryellen N. Kos	ydar/Daugh	ter				11 Road,			.015		
other tr	2	Oa. Method of Disposition		20b. Pl	ece of Dispos	sition (No	ome of	ne)	Dete	20c. Location - (	City or To	wn, State	
·		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☒ Other (Specify		- 7				Gardens	3/15/99	Bel Air	, MD		
Baltimore, permit. Pages 1 at Department of Hee Department of Hee any Injury or othe page.	2	21. Signature of Funeral Service Licen		9	22.	Name e	nd Addre	ss of Fecility McComas					
_ 45244		marle Un	my h.		13	317	Coke	sbury Roa	ad. Abin	adon, MD			
		23a. Pert1. Enter the diseese, or comp shock, or heert failure. List only	olications in caused in one on the caused line	the deeth. e.	. Do not ente	or the mo	de of dyi	ng, such es cardie	c or respiretory e	rrest,	i	Approxime Interval Be Onset end	etween
/ Physician /Medical Examiner		mmediate Cause (Finel disease or condition esulting in deeth)	a. alu	Due to (or	as a consequ			hem	alime	t,		4 2	4 +31
68760, flicate be executed g physician and as the burial-transit	CXamilin	Sequentially list conditions, lany, leading to immediate cause. Enter Underlying cause (Disease or Injury	b	Due to (or	es a consequ	uenca of	):				1		
E 08		Cause (Disease or injury het initieted events esulting in death) Last	c	Due to (or es a consequence of):					VI I				
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the der	P	ert II. Other aignificant conditions co	ontributing to death but	t not resul	lting in the un	derlying	cause gi	en in Pert I.	23b. Dfd	tobacco una con	tribute to	the cause	of death?
									10	Yea 2□ No	3 Pro	bably 4	Unknown
( ) ~ 1000 -		. BURGET					9		24e. Wes	an autopsy rmed?	ev co	era eutopsy ailable prior impletion of deeth?	rto
	5								10	Yes 2 No	16	☐Yes 20	□ No
Vital I		5. Wes case referred to medical						26. Piece of De	eth (Check only	one)			
	0	examiner?	Hospitel:	nt 2 🗆 E	R/Outpatient	3 🗆 🖸	OA OH	API A		dence 6 □Othe	r (Specil	(ע'	
g Physic residing		7. Manner of Deeth	28e. Dete of Injury (Month, Day	Year)	28b. Time of fnjury		28c. Inju Wo		7	how injury occurre			
VISION Attending In death. ector: After by the fune	2	1 Neturel 5 ☐ Pending investigation		r oar/	injury	М		Yes 2□No					
Division of the function of Director. After the following the funeral control of Director.		3 Suicide 6 Could not be determined	28e. Plece of Injurbuilding, etc.	ry - At hor (Specify)	ne, farm, stre	et, fecto	ry, office		28f. Location ( City or To	Street and Numbern, Stete)	er or Rure	il Route Nu	mber,
Hospit Puner Tuner tely fill		29e. Certifier Certifying Phyone) Certifying Phyone	/sician: To the best of liner; On the basis of and manner stet	examineti	riedge, deeth on end/or inv	occurre estigatio	d at the ti	ne, date and place pinion, deeth occ	e, end due to the urred at the time,	ceuse(s) end mer date end plece, a	nner as s ind dua te	tated. the cause	(s)
within 2 To the comple	29b. Signeture and title of certifier 29c. License number									29d. Date signed	(Month,	Dey, Year)	
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10	3	0. Neme and address of person who o						5(1		NO CA	, ,,	1170	
					MACI	PhA	. ]						
State Registrar		1. Dete filed (Month, Day, Year)	32. Regitiral	s Signet	D.		bon	this.					

ANG 15 1993

or see the measure

**Physician** /Medical

**Examiner** 

Funeral Director

Be Completed by

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel thygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evarance must be notified at

	Please	Type or	Print	In Blaci	k Ind	elible	lnk	. Assu	ire A	II Copie	s Ar	e Leç	jible.		
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1. Decedant's Nama (Firs	st, Middla, La	ist)								2. Data of D	Daath	Day	Year	3. Ti	ima ot Death
		ine Au		Otwe1	11					Marc	h	3	1999	1 1	938
4a Facility Nama (If not in	institution, giv	va straat and nu	umber)							Location of Dee			nty of Death		
The Mem		1 Hosp	ital					East				Talk			
5. Social Sacurity Number	1		7. Aga (II	In yrs. last birti		If Undar 1 Months	1 Yaar Deys		24 Hrs. Min.	8. Deta of B	sirth Day, Ye	ear)	9. Birth	nplace (S	Stata or Foraign
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10e. Street end Number						10f. Zip Coda 10g. Citizan of What						What Cou	intry?		
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Jol	hn Sin	mon Po	land					Lu	11a_	Foutz					
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1 X Buriel 2 ☐ Crer 4 ☐ Donation 5 ☐ C				Concor		etory or oth emete				3/8/99	ne	ear I	ento	n. M	aryland
21. Signature Funaral	Sarvice Licar	nsee		00	22. N	Nama and	Addra	ass of Facility	ty		1	-02	Cit	1,	AL Jane
Haudo	phi.	( poor	_		1 _					P.A.	Dent	ton,	Mary	1 and	21629
23a. Part1. Entar tha dise shock, or haert teilu	easa, or com- ura. List only	plicetions that on a causa on i	aused the	daath. Do n									1100	Appro:	oximate val Betwaen ot end Death
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resulting in death)		a	O Du	e to (or as a c		ence of):		-					1		days
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Causa. Entar Undarlying Ceuse (Disaese or Injury	1	C													
that initiated avents rasulting in death) Last			Due	a to (or as a co	onseque	anca ot):									
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Dial	etes	2								1[	□Yes	2 DNO		of death?	2000
25. Wes casa reterred to								26 Place	ot Das	ath (Chack only	ly one)				

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burlet-transit

Be Completed by

Medical Certification: To

29a. Cartifiar (Check only one)

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner Sequentially if any, laadin-causa. Entai Ceuse (Disac that Initiated rasulting in d Part II. Othar

25. Wes casa axaminar? 1 Yas 2 No 27. Manner of Daeth 1 Natural

29b. Signatura and titla of certifier

5 Panding Investigation 2 Accident 6 Could not be detarmined 3 Suicida 4 Homicida

1 Impatient 2 ☐ ER/Outpatiant 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury

28a. Pleca of Injury - At homa, farm, streat, tactory, office building, etc. (Specify)

1 ☐ Yas 2 ☐ No

PYTYPG

Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 28c. Injury at Work? 28d. Dascribe how injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

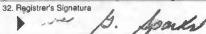
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Dete signed (Month, Dey, Yeer)

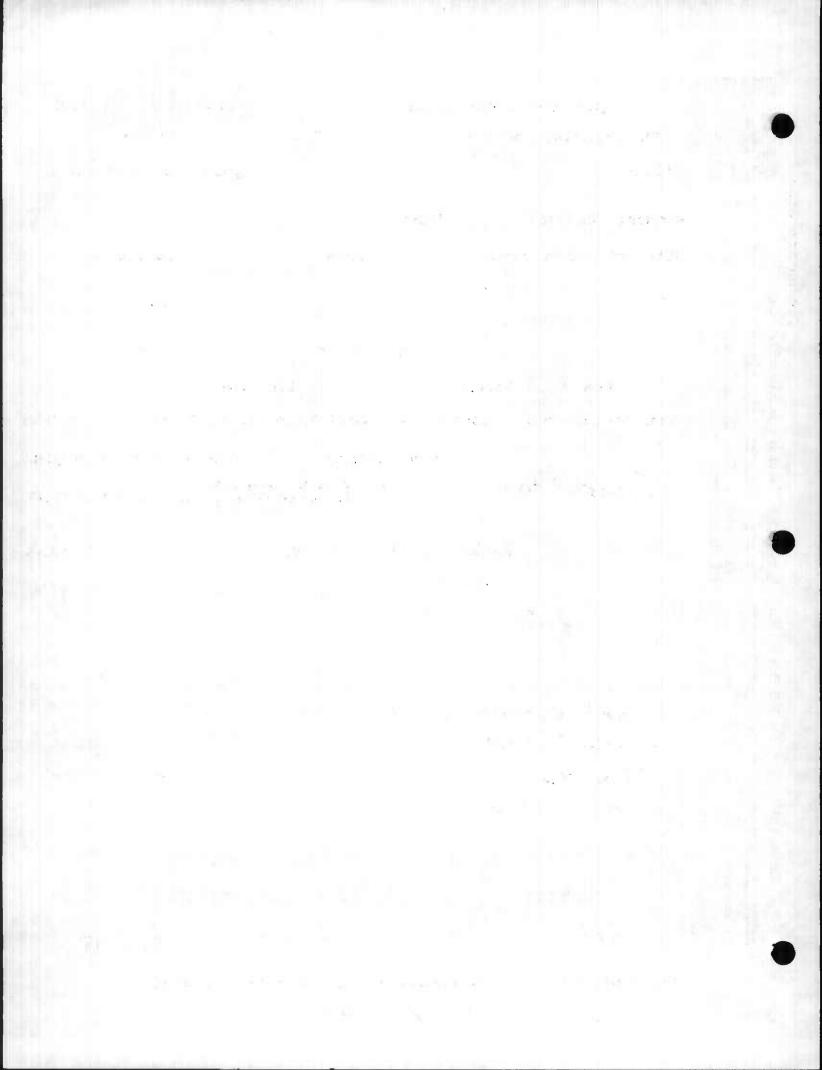
MD 30. Name and address of person who completed cause ot deeth (Item 23a) (Type, Print)

Peter Whitesell, M.D., 508 Idlewild Avenue, Easton, Maryland 21601 31. Data tilad (Month, Day, Yaar)

State Registrar

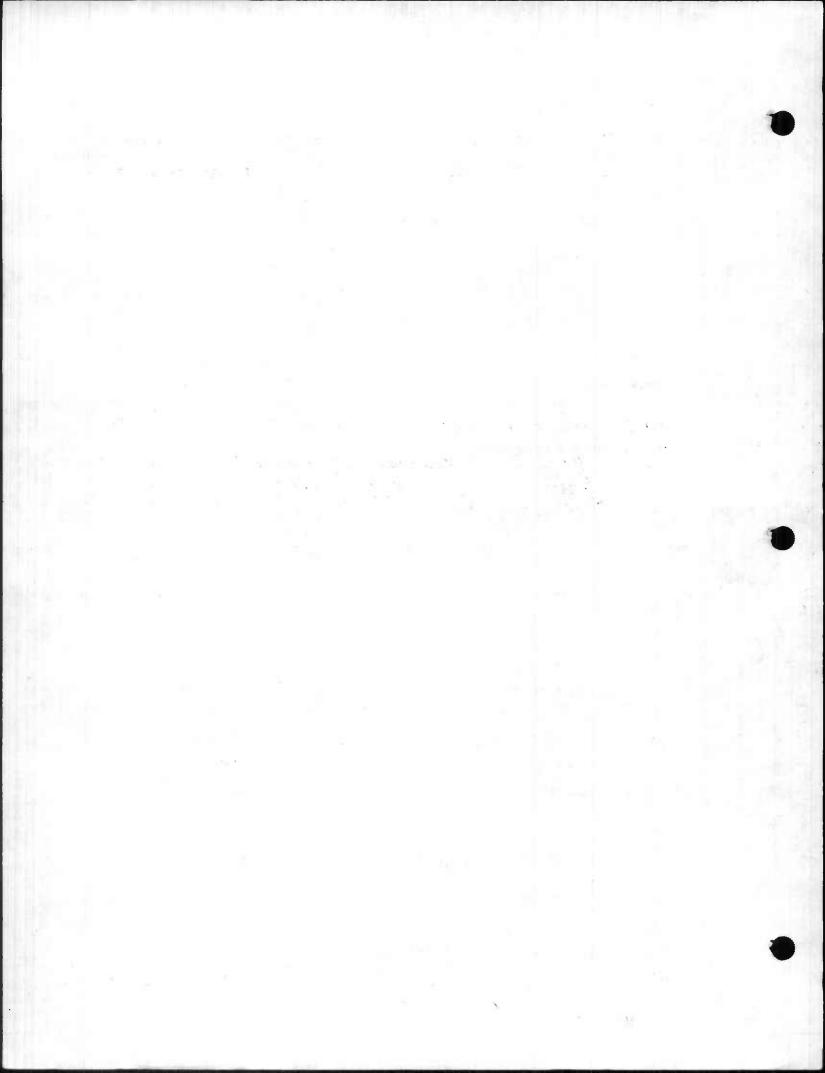






## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 01.91

			Certificate of	Death	Reg	g. No.	0 3 4 0 1				
Dhuaisian	1. Decedent's Name (First, Middle, La	st)			2. Dete of Death Month		3. Time of Death				
Physician /Medical	Ella Mae Spic	cer			March 7,		0450				
Examiner	4a Facility Name (If not institution, giv			4b. City, Town, or Lo	ocation of Death	4c. County of I	Death				
	Harford Memoria	. Hospital		Havre de		Harf	ord				
Funeral	5. Social Security Number 6. S	ex 7. Age (In yrs. las.	Months   Dev		8. Dete of Birth (Month, Dey, )	Year) 9.	Birthpiace (Stete or Foreign Country)				
Director	215-28-7485	66	Yrs.		Mar. 8,	1932 M	aryland				
Pu &	Usual Residence of Decedent  10a. Stata 10b. County	10c City T	Town or Location				10d. Inside City Limits				
h the Merylan c 28e-f show incritised at			OWN OF COCATION				1 ☐ Yes 2 ☑ No				
oto	Maryland Harford	Jo	pppa								
E 0 M O	10e. Street and Number		10f. Zip Code		100	it Country?					
23 W		a Road	210	85		US	A				
frac death of the control of the con	11. Marital Status	12. Wes Decedent Ever in U,S. Armed Forces?	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp. ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.				
d within 72 hours after pleas. The Medical Escrib		1 ☐ Yes ② No If Yes, Give	1 ☐ Yes 2 ဩN	o Specify:		Specify: \					
72 hours and matural, o		Year or Dates:	The state of the s			ороспу.	MILCO				
led within 72 ho yglene. Ar then "natura nt, the Maccell Completed	15. Decedent's Ed (Specify only highest gra		6a. Decedent's Usuel Occi (Give kind of work don life. DO NOT use retir	upation e during most of work	ing 16	6b. Kind of Busin	ness/Industry				
filled within Hyglens. ther than and, the Man	Elementary/Secondary (0-12)	College (1-4or 5+)		red)							
Hydler The Hydler Cor	12		Homemaker			Own Hor					
	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma						
Z should be if and Mental H is marked of reumatic avar	Maurice C. I	Fitch		Helen	P. S	mith					
of building	19a. Informent's Name/Relationship (	Type, Print)	19b. Mailing Address (Street	et end Number or Run	al Route Number, (	City or Town, Sta	ate, Zip Code)				
CENE	Samuel J. Spicer.	Sr. / Husband	1407 Philade	Inhia Road	Toppa.	MD 210	85				
f Heat f Heat fram 2 other	20a. Method of Disposition	20b. Plac	e of Disposition (Neme of			Oc. Location - Cit					
Pages net if h	1 ☑ Buriel 2 ☐ Cremetion 3 ☐	Hemovel from Stete	etery, cremetory or other p		3-10-99						
5.5.2	4 □ Donation 5 □ Other (Specifical Service Inches	Zior	Evangelical	Luth.Cem	S	temmers	Run, Maryla				
Depart mport any in	21. Signatury of Pullerar Selvice Brog	ral Home, P.A.									
402 40	/tanastx XII	and the		sbury Road			•				
	23a. Perit1. Enter the discussion of com- shock, or heart feilure. List only	Meations that caused the death.	Do not enter the mode of d	ying, such es cardiac	or respiretory erres	it,	Approximete Intervel Between				
Physician		11 1 1					Onset and Deeth				
/Medical	Immediate Cause (Finat disease or condition	Stableyro	Collax X	udoca	ldily	2					
Examiner	resulting in death)	a Duyaran	s a consequence of):				1				
<u> </u>		Due to (or a	a a consequence ory.								
physician and is the burletransit		b					1				
physician and s the burlet-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequence of):								
burd B	Cause Enter Underlying Cause (Disease or injury	C	25	numan off:							
that of	that initiated events resulting in death) Last	Due to (or as	e consequence of):								
2 0 4											
for use							T				
d by the attandir latached for usa Physician/A	Part It. Other significant conditions of	ontributing to death but not resulting	ng in the underlying cause of	given in Pert I.	23b. Did tob	acco use contri	bute to the cause of death				
	terminal	Vine Cal	16 home	2	Yes	8 2□ No 3	☐ Probably 4 ☐ Unknow				
bene bed yd	1. 11.10.01.00.01	0	10-10-011								
cate has been signed by personal completed by Pl	adirmied	animic o	GSTYUCKUN	e bullun	Le 242 Wes en	eutopsy 2	24b. Were eutopsy findings eveilable prior to				
4 - C	K		07 .0.00	0	1	301	completion of cause of deeth?				
- 2 =	di.	Sur			1 ☐ Yes	20 No	1 ☐ Yes 2 ☐ No				
C Cat							10 162 50 140				
s cartificate director, pay	25. Wes case referred to medical axaminer?	Hospital:	10	26. Place of Deet	h (Check only one)						
를 구	1 Yes 20 No	1 2 Inpetient 2 □ ER	VOutpatient 3LI DOA	4 LI Nursing Ho	ome 5 Residen						
n 24 hours after death.  Ne Funeral Director: After this cartific pletaly filled in by tha funeral director, edical Certification: To Be (	27. Manner of Death	28a. Date of Injury (Month, Day Year)	8b. Time of 28c. Inj Injury W	ork?	28d. Describe how	v injury occurred					
death. Hor: A / the fu	2 ☐ Accident investigation		M 11	Tyes 2□No							
by th	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, offic	9	28f. Location (Stre		or Rural Route Number,				
within 24 hours after de To the Funeral Direct completaly filled in by the Medical Certific	4 Littoriado	bulliang, etc. (Specify)			Ony or rown,	Olale)					
al Alexander	29a. Certifier Certifying Ph	ysician: To the best of my knowle	dge, death occurred et the	time, date end place,	end due to the ceu	use(s) and menn	er as steted.				
S S S	(Check only 2 Medical Exam	iner: On the basis of examinetion and manner stated.	and/or investigation, in my	opinion, deeth occurr	red et the time, dat	e and plece, and	due to the cause(s)				
N ap	29b. Signature and title of certifier		29c. Lice	nse number	290	d. Date signed (/	Month, Day, Year)				
F 8		2 3/11	(., / ]	77776	C MI	1000	2 1999				
	run	March +, 1917									
10	30. Nama and address of person who	completed cause of death (Item 23	Sa) (Type, Print)	a Af a	2001	4.1.	·6. A				
	HONE JUNK	M, 17 W	allul Lah	y risk	well,	au	yeurs .				
State	31. Date filed (Month, Day, Year)	32. Registrer's Signeture	0 / /								
Registrar	MAR - 0 199	19 Deperson	D. Soon	Sal .							
	- INIMIN B 13.	-	1 1	-							



							Ce	rtificate d	of Dea	ath		Reg. No.	0	J 0.62
			1. Decedent's Name	(First, Middle, L	ast)				10.0		2. Dete of Da		Vana	3. Time of Death
П	Physician		Sarah	Eliz	abeth	Stephe	ens				MARCH	By 19	Year 99	5:40PM
8	/Medical Examine	_	4a Facility Neme (If						4b. Cit	y, Town, or L	ocation of Death			
A	LXaiiiiici	ı	Fallston	Genera	l Hospita	a1			Fa	llston		н	arfo	m
	Funeral		5. Sociei Security No			7. Age (In yrs.	lest birthday)	If Under 1 Y	ear If U	nder 24 Hrs.	8. Dete of Bird (Month, Da			plece (Stete or Foreigntry)
т	Director		212-20-63	346	10 M XXF	ha-ab- David			eys Ho	urs Min.	NOV 27			tucky
			Usual Rasidanca of			00					1400 . 21	, 1912	VEII	cucky
	/lanc												10d. Inside City Limits	
	Man Han	5 1/	Maryland	Harfo	Ба		Edgewo	500						1 ☐ Yes 2€ No
	or 28s-fs	6	10e. Street end Num		Lu		rugewo	10f. Zip Coo	de			10g. Citizen of	What Cou	ntry?
	1 N N N N N N N N N N N N N N N N N N N		3803 Will	anappaz.	Boach Po	Бе			210	110		USA		
	efter death with the Marylan or flems 23a or 28a-f show offer shart be notified at Finneral Director	0	11. Maritel Stetus	ouginy .	12. Was Dece		S 13	Was Decedent			ecify Yes or No			can Indien,
	ter d	5	1 Never Merrie	ad 20 Marriad	Armed For	ces?		If Yes, specify (	Cuban, Me	xican, Puerto	ecify Yes or No Rican, etc.)	Ble	ck, White	
d 21215-0020	urs eff.		3 ₩idowed	If Yes, Give	If Yes, Give 1 Year or Detes:		1 Ves 2 No Specify:				Specif	v: Wh	ite	
	natural', notes Ex	2	×	15. Decedent's I					te Heuel Occupation			16b. Kind of Business/Industry		
	ed within 72 hor ygiene. her than "natura it, its Modes!			ify only highest g	rade completed)	completed)		<ol> <li>Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)</li> </ol>			king	TOD. TRITIC OF D	. Mild of Dustrious moustry	
	within then then		Elementery/Secon	ndary (0-12)	College (1-	4or 5+)		emaker				Own H	omo	
	EIDE a		17. Fether's Name (	First, Middle, Las	at)		none	allaket	18. N	Aother's Nem	e (First, Middle	Meiden Sumer		
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re,	s 1 end f Health tem 27 other tr				e/ Daugh		3	stion (Neme o		wy, w.		sh, MD		
	8-20		20a. Method of Disp 15 Burial 2		☐Removal from S		emetery, cre	netory or other	plece)		Date	20c. Location	City or 1	own, State
	permit. Pege Department of important: if any injury or once.			5 ☐ Other (Spec			hview	Memoria	al Ga	rdens3	3-11-99	Fallsto	n, M	aryland
a	Semit. Pe Separtmet mportant any injury		21. Signature of Fur	neral Service Lice	ensee		2	Name end A	ddress of F	acility COmas	TIT Fu	meral H	ome.	P.A.
m	82558	1	Must	1.11	Hund							ngdon,		
		+	23a. Pert1. Enter th shock, or heer	a disease, or co	mplicetions that ca	used the deet	h. Do not en							Approximate Intervel Between
	Physician		snock, or neer	t leliure. List oni	y one pause on a	ech line.							1	Onset end Deeth
5	/Medical		Immediete Ceuse (i		Dro I	DIET 7		meeli			FA (1	1.17.00	1	
	Examiner		disease or condition resulting in deeth)  a. PER IPHERAL CURCULATORY FAILURE  Dua to (or as e consequence of):											
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	executed n end iel-transit				b. SE	-		augnos off:		-				
,	icate be executed physician end s the bunel-transit	2	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disaasa or injury c. URIVARY TRACT INFECTION											
290	sicia bur	0	cause. Enter Underlying Causa (Disaasa or injury thet initieted events  Pue to (or se a consequence of):											
68760,	entificate be executed ling physician end lie es the buriel-transi	5	resulting in death) Last  Due to (or as a consequence of):											
×	seath certificate of the use est the for use est the following phase of the use est the following th	2												
Bo	et the death of the ettendeteched for us	5												
of Vital Records, P.O Physician: The law requires that the	the d	7 2	Part II. Other signifi	cant conditions	contributing to de	ath but not res	ulting in the u	nderlying caus	e given in I	Pert I.				to the cause of death
	thet the death ed by the ette deteched for		HYPERN	VATRE	MIA						10	Yes 2 No	3 Pro	obably 4 Onknow
	8 58 6	2											245 14	More outerou findings
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	hes b	2	O Corio		1001								0	f death?
	The in	5	ATRIAL	FIB.	RILLA	TIDN					10	Yes 2 No	1	☐ Yes 2☐ No
	certificate rector, pag		25. Wes casa rafarr	1 100		/			26.	Placa of Dae	th (Check only	ona)		
	hysician: his certific il director.	>	axeminer? 1 ☐ Yas 2 ☑ ∕1	40	Hospital:	patient 2	ER/Outpatie	nt 3 DOA	Other: 4	☐ Nursing He	ome 5 Resi	denca 6 Oti	ner (Spec	ify)
	After this funeral d		27. Manner of Death		28a. Data o	f Injury n, Dey Yaar)	28b. Time o	f 28c.	Injury at Work?		28d. Describa	how Injury occu	rred	
0	Attending F r death. ector: After by the funer iffication:		1 ⊠Natural 2 ☐ Accidant	5 Pending investigeti		r, Doy raary	Hijory		1 ☐ Yes	2 🗆 No				
Division	effer death Director: A In by the f		3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, offi						fice 28f. Location (Street and Number or Rural Route Number,					
Ö	tal or Attending P rs after death. al Director: After t led in by the funera Certification:		4 Homicide building, etc. (Specify)											
	spitus nour nera		29a. Certifiar	1 Certifying P	hystolan: To the l	best of my kno	wiedga, daat	n occurred at th	ne time, de	te end plece,	and dua to tha	causa(s) and m	ennar es	stated.
	To the Hospital or Attend within 24 hours after deal To the Funeral Director: completely filled in by the	2	(Check only one)	2 ☐ Medicat Exa	miner: On the ba and mann	sis of examine	tion end/or in	vestigation, In	my oplnion	, deeth occur	rred et tha time,	data and place,	and dua	to the causa(s)
	orth or the comp		29b. Signature and t	titje of certifier				29c. Li	cense num	nber		29d. Dete signe	ed (Month	, Dey, Year)
	->-0		► MA.	Ahl.	ian R	2v 1	AN	1	750	727		March	9	1999
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	10	A	30. Name end addre	1 LRI	complated cause	O death (Itan	1 238) (Type,	1 1=	7/117	- ar	) //6	117	29	1000
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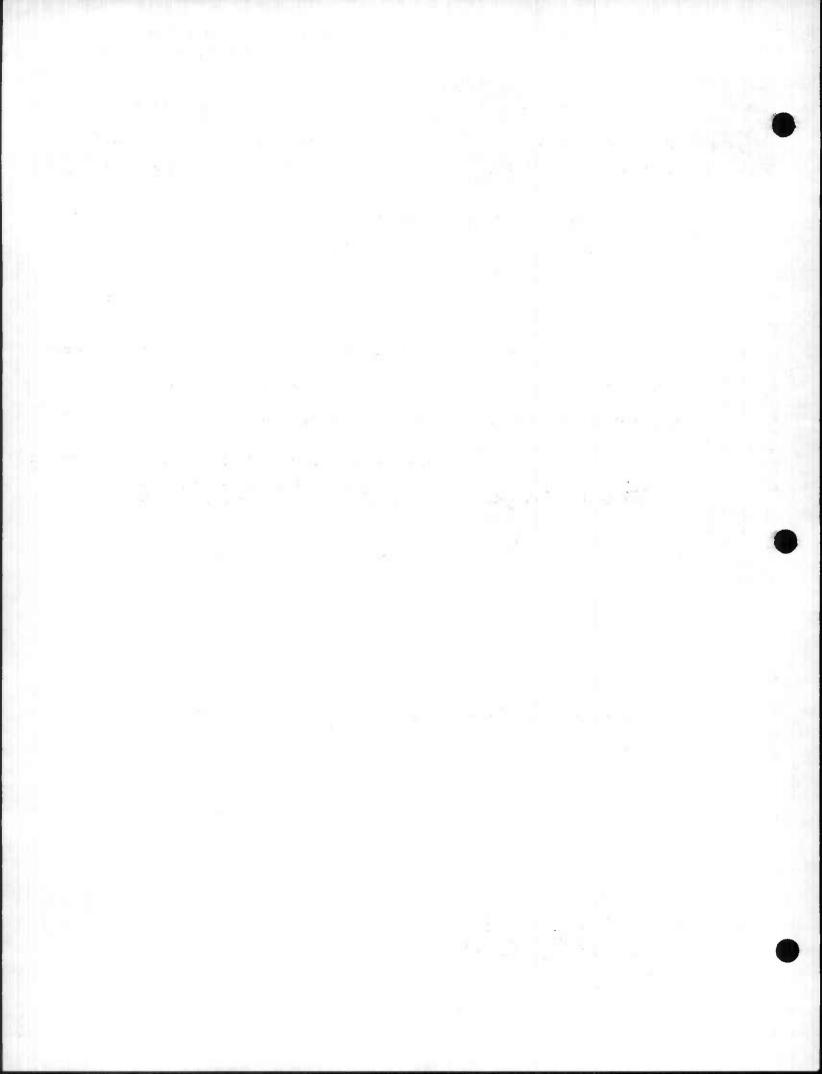
DHMH 16 Rev 6/95

Registrar

REEL BE HAM

State of Maryland / Department of Health and Mental Hygiene

				Co	ertificate of		Re	g. No.	09483			
п	Physici	ian	Decedent's Neme (First, Middle, Last)		2. Dete of D Month		Day Yes	3. Time of Death				
A	/Medi		Mildred Helen Shockle				March 6		11:00 AM			
A	Examir	ner	4e. Facility Neme (If not institution, give street end num		4b. City, Town, or Location of Deeth Goldsboro Garoline							
_			342 Railroad Ave.  5. Social Security Number 6. Sex 7	. Age (In yrs. lest birthda	v) If Under 1 Year	Goldsbor	8. Date of Birth					
Baltimore, Maryland 21215-0020	Funeral Director	rector	221-14-5741  Usuel Residence of Decedent	73 Yrs.	Months Deys	Hours Min.	Oct. 11	, Dey, Year) Country)				
	Aaryland Fahow		10a. Stete 10b. County		City, Town or Location 10d. Inside City Limits Goldsboro 1⊠Yes 2□No							
	28a-		Maryland Caroline  10e. Street and Number	GOTUSI	10f. Zip Code		10	g. Citizen of Whet				
	ath with	Funeral Director	342 Railroad Ave.		2163			U.S.A.	Country			
	filed within 72 hours after death with the Maryland Hydiana "hetural", or fleme 23a or 28a-f ahow th, the Madical Examination must be notified at	To Be Completed by Fune	11. Maritel Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Deced Armed Ford  1 □ Yes 2 If Yes, Give Year or Decentified Ford  1 □ Yes 2 If Yes, Give Year or Decentified Ford  1 □ Yes 3 □ Widowed Ford  1 □ Yes 5 □ Widowed Ford	ZNo	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🕱 No		ecify Yes or No- Rican, etc.)	Black, W	merican Indien, hite, etc. White			
			15. Decedent's Education (Specify only highest grede completed)  Elementery/Secondery (0-12)  College (1-	(Gir	16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) bookkeeper			retail grocery s				
	e filed will Hygian other th		12	boo								
	a la b		17. Father's Neme (First, Middle, Last) Harry LaVere	Mildred H								
	d 2 should be th end Menta 7 is marked traumatic ex		19e. Informent's Neme/Reletionship (Type, Print)	rai Route Number, City or Town, State, Zip Code)								
	S Les		Robert G. Shockley/ husb		Railroad		dsboro,					
	of Healt fram 2 r other		20e. Method of Disposition	com a fa ne at	position (Neme of remetory or other ple	ce)	Dete 20	Oc. Location - City	or Town, Stete			
	Pag ment ant: H		1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from S 4 ☐ Donetion 5 ☐ Other (Specify)	919	nsboro Cen		3/10	reensbor	o, Maryland			
Balt	permit. Pages 1 Depertment of H important: If its any injury or ot once.		21. Signeture of Funeral Servica Licensee		eral Home, PA							
	-		P.O. Box 160 Greensboro, MD 21639  23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.  Approximate intervel Between									
	Physician /Medical Examiner	ner	Immediate Ceuse (Finel disease or condition resulting in deeth)	dden De		spect M	lyocardial	Infact	Onset end Death			
on of Vital Records, P.O. Box	tificata be axecuted g physician and as the burial-transit	ın/Medicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  Due to (or es e consequence of):  Due to (or es e consequence of):									
	ding ding		resulting In deeth) Lest									
	he att	Physician/N	Pert II. Other significant conditions contributing to dea	th but not resulting in the	ulting in the underlying cause given in Pert I.			23b. Did tobacco use contribute to the cause of death?				
	es that the death cer igned by the attendir be datached for use	Be Completed by	Thrombocytopenia, Ch	tructive	Palmonary 1 1 No 3 Probet			Probably 4 Unknown				
	The law required the law required to the law r		Disease, Arthri	tis				24e. Wes en eutopsy performed? 24b. Were eutopsy evellable completic of death?				
							1 ☐ Yes	20 No	1 ☐ Yes 2 ☐ No			
	ysician: The		25. Wes case referred to medical exeminer?			h (Check only one,	)					
	2 00	70	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ In		ent all box	Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)						
	To the Hospital or Attending Ph within 24 hours elited deeth. To the Funeral Director: After thi completely filled in by the funeral	Certification:	2 Accident investigation		28b. Time of Injury et Work?  M 28c. Injury et Work?  1 ☐ Yes 2 ☐ No			28d. Describe how Injury occurred				
			3 ☐ Suicide 6 ☐ Could not be determined 28e. Pleca o building	f Injury - At home, farm, s , etc. <i>(Specify)</i>	street, fectory, offica	City or Town, State)						
	Hosp. 24 hou Funer staly fill	edical	29e. Certifier (Check only one)  Certifying Phyelcian: To the b	is of examinetion end/or l	eth occurred et the time	me, dete end plece, opinion, deeth occurr	end due to the ceu ed et the time, det	use(s) end manner e end plece, end c	as steted. due to the ceuse(s)			
	o the	Mec	29b. Signature and title of certifier	saled.	29c. Licens			d. Date signed (Mo				
	- ≯ <del>-</del> ŏ		DO WAY	I to mo	1			2/0/	99			
			30. Name and address of person who completed cause		J. Print)	D47492		3/8/	( ]			
			Jeffrey Denton, 1	D F	3BJX 12	2 G	oldsboro	mD 2	1436			
	Sta Registr	_	MAR 0 7 1999	pistrer's Signeture	1. 1							



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time the SING ATHAN 0335 Am MARCHT 091999 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year Months Deys Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 6. Sex 1 2 M 2 □ F 7. Age (In yrs. lest birthday) Months 236-50-0633 64 Jan. 31, 1935 West Virginia Usuei Residence of Decedent 10e. State 10b. County 10c. Cify, Town or Location 10d. Inside City Limits Frederick 1 ☐ Yes 2 No Maryland Montgomery Rockville Frederick 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4029 Araby Church Road 21701 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 1 Never Married 2 Merried 1 Yes 2 XNo If Yes, Give Yeer or Dates: 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Landscraper Horticulture 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Ned H. Sine Jessie Funk 19e. Informent's Name/Relationship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) P. O. Box 229, Bunker Hill, West Virginia 25413 Louise Smith/Sister 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) Enders & Shirley Funeral Home & Crematory 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Burlai 2 ☐ Cremetion 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) Berryville, Virginia 22. Name end Address of Fecility Enders & Shirley Funeral Home P. O. Box 757, Stephens City, Virginia 22655 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximete intervei Between Onset end Deeth Immediete Ceuse (Finai SEPTIL SHOCK TWO DAYS disease or condition resulting in deeth) NEUMONIA Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were sutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

p

Completed

Be 2

Funera!

Director

with the Marylend

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Health and Mental Hygiane.
Important: if item 27 is marked other than "naturel", or items 23s or 28s-4 show any fully or other traumatic event, I'm Medical Expriner matter be notilised at

Saltimore, Maryland 21215-0020

Box 68760.

Records, P.O.

Division of Vital

Physician/Medical by Completed Be 1º

1 Yes 2 No

5 Pending Investigation

6 Could not be determined

27. Menner of Deeth

1 Naturel

2 Accident

4 Homicide

(Check only

3 Sulcide

29a. Certifier

Examiner

signed by the a should I page 2 s cartificate Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this carifice funeral in by the 24 hours

ician and buriel-transit Certification:

physician a the buriel esn Medical within 2

State Registrar

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner stated.

28e. Date of Injury (Month, Dey Year)

28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number DUU 52927

1 Yes 2 No

28c. Injury et Work?

Cartifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner es stated.

29d. Date signed (Month, Dey, Year) M MRCH. 09,

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

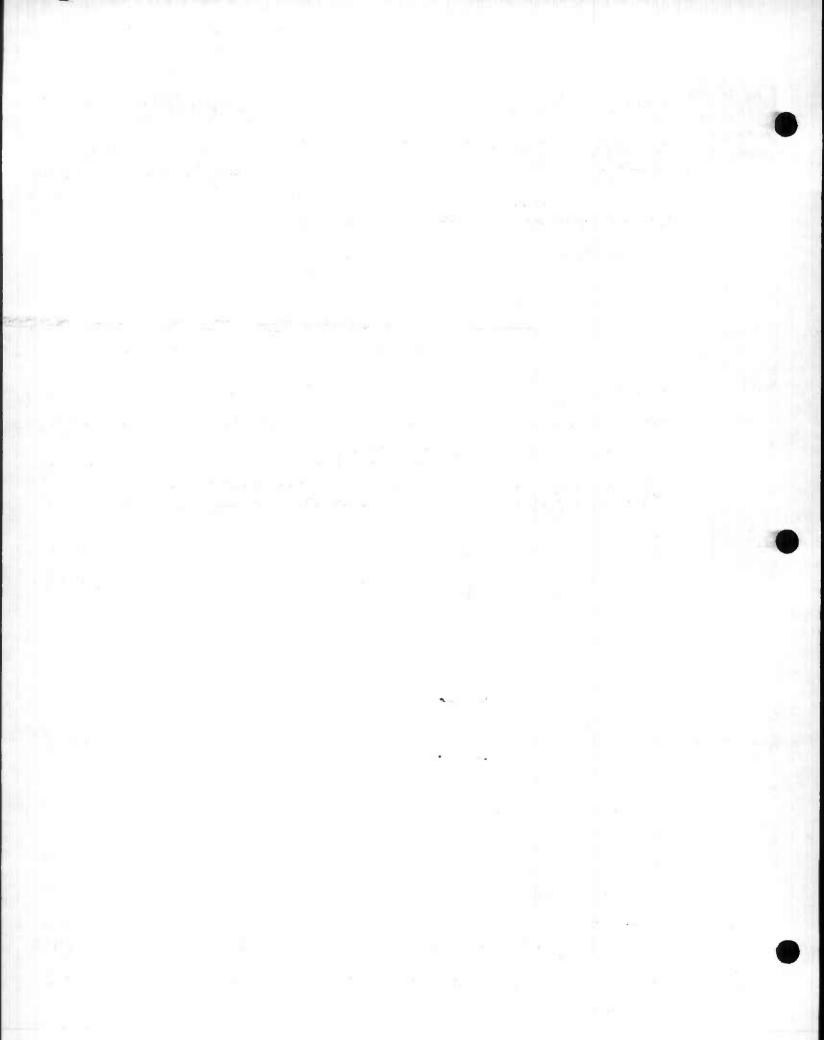
Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

ess of person who completed cause of cleeth (Item 23e) (Type, Print)

I GWEBE, SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE, MD. THEODERS 31. Dete filed (Month, Day, Y

23 1999 32. Registrer's Signeture



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ravers WILLARD 09 5:10 P.M James 1999 March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bay Center of hirthday If Under 1 Cake Month, Day, Dorchester 10/10RD 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 83 Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 10M 20 F Months Deys 213-12-534 Mary land Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Dorchester 1 Yes 2 No ambridge 10e. Street and Number 10g, Citizen of What Country? Avenue 520 G lenburn USA 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 E No if Yes, Give Yeer or Dales: 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Black 3 Widowed 4 □ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Labor Seafood Industry 6 17. Father's Neme (First, Middle, Last) Daniel TRAVERS (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 51 Webbs Lane Apt. 3 Dover Delaware 19904 20c. Location - City or Town, State James R. Travers 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 3/13/99 1 Burial 2 Cremation 3 Removal from State Snithville Cemetery Taylors Island, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Home P.A. FUNERal 23a. Pahl. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate Approximate Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Łast

**Physician** /Medicai Examiner

Baltimore, Maryland 21215-0020

**Physician** 

/Medical

**Examiner** 

10a State

by Funeral Director

Completed

Be

the Medical

Hygiene.

Pages 1 and 2 should be fill ment of Health and Mental H-bent: If Nem 27 is marked oth lury or other traumatic even

**Funeral** 

Director

Examiner the buriel-transit icai signed t hours after death.

neral Director: After this y filled in by the funeral di

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Part II. Other significant conditions	contributing to death but not re-	sulting In the underlying	cause given in Part I.	23b. Did tobacco use co	ntribute to the cause of death? 3 Probably 4 Unknow	
				24a. Was an eutopsy performed?	24b. Were autopsy findings eveilable prior to completion of cause of death?	
25. Wes case referred to medical			00 81 18	1 Yes 2 No	1 Yes 2 No	
examiner?	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐ Do	h (Check only one) ome 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death  1. Naturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred		
3 Suicide 6 Could not to determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fector	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)			

State Registrar

Ahmed Nawaz 31. Date filed (Month, Day, Year)

29b. Signeture end title of certifier

105 32. Registrar's Signature

30. Name end eddress of person was completed cause of death (Item 23a) (Type, Print)

Aurona

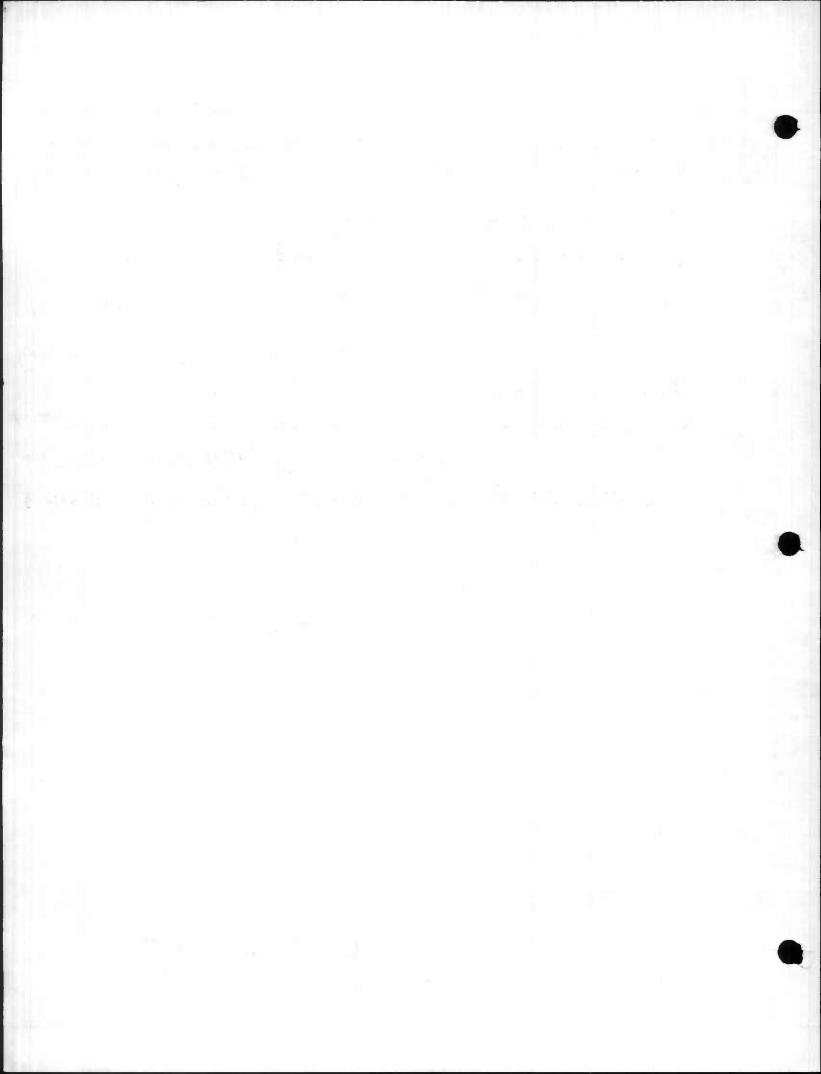
29c. License number

29d. Date signed (Month, Day, Year)

mo

21613

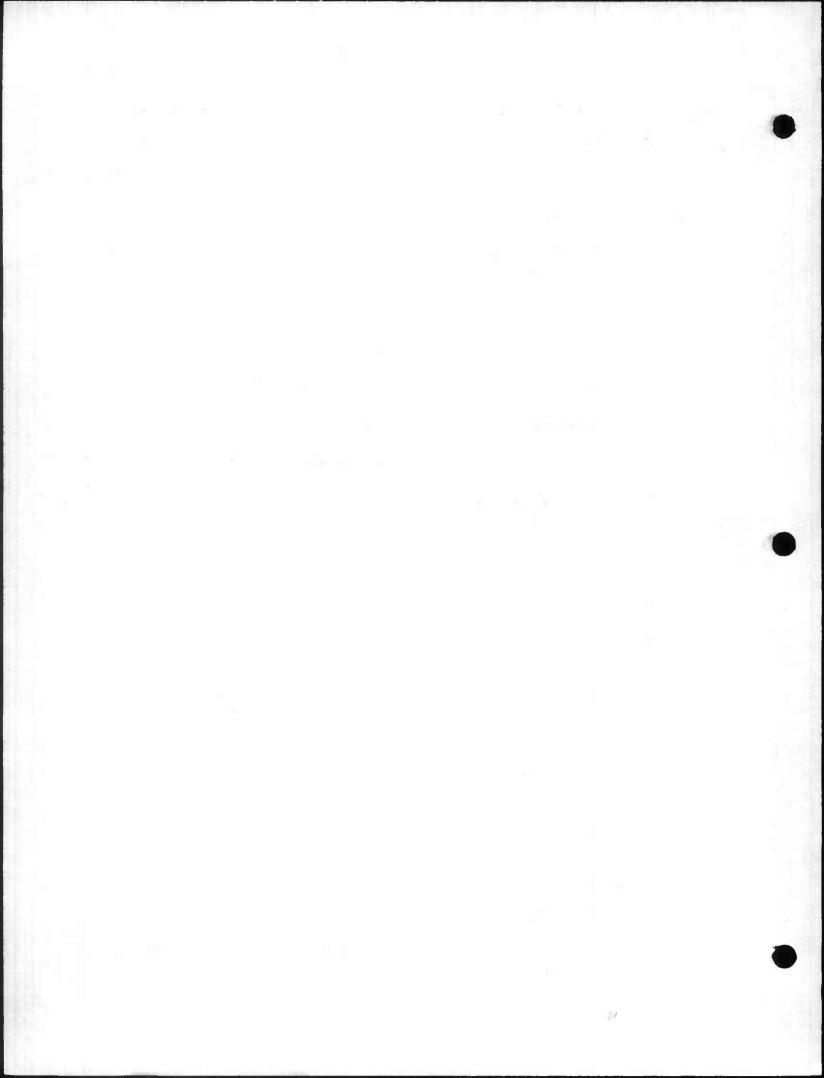
To the Hospital c within 24 hours at To the Funeral D completely filled



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** MARCH 6, 1999 0305AM JOHN TOWNSEND CLARK /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Lusby 13061 Mills Creek Drive Calvert If Under 1 Yeer If Under 24 Hrs. Months Deys Hours Min. Nov. 23, 1 5. Social Security Number 9. Birthplaca (State or Foreign Country) Virginia 7. Age (In yrs. lest birthday) **Funeral** 110 M 2□ F Yrs. Director 68 1930 579 42 2729 Usual Residence of Deceden the Manyland 10a Stete 10h Counts 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or frame 23s or 28s-f show the Medical Examiner must be notified at Maryland Calvert Lusby 1 ☐ Yes 2 No Director 10e. Street end Number 10g. Citizen of Whet Country? United States 10f. Zip Code with 13061 Mills Creek Drive 20657 Funeral death 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ⊠ Yes 2 □ No 1951
If Yes, Give
Yeer or Detes: to 11 Meritel Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Merried White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced 195 Sec. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pemit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumants aven? Elementery/Secondary (0-12) College (1-4or 5+) Tax consultant Business & Finance 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Ruth Johns Byrne John Clark Townsend 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jean Dirska/ companion same as 10 20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriet 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/7/99 Alexandria, Virginia 22. Nerme end Address of Fecility Rausch Funeral Home, P.A. 21. Signeture of Funerel Service Licensee 4405 Broomes Island Rd., Port Republic,MD 20676 LKEK and. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, nock, or heart failure. List only one cause on each line Approximete Interval Between Onset end Death Physician' /Medical Immediate Cause (Final liver Cancer nine months disease or condition resulting in deeth) Examiner Due to (or es a consequenca of): physician and s the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Box 68760. 8 Physician/Medical Due to (or as e consequence of): 88 attending for P.O. | signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown Records. by 24b. Were eutopsy findings eveilable prior to Completed 24a. Wes an autopsy peed completion of cause of death? page 2 s has 1 ☐ Yes 2 1 No certificate 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medical examiner? 26. Pleca of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 1 Yes 2 No 2 this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After t Certification: 5 Pending Investigation 1 Neturel death. 1 ☐ Yes 2 ☐ No Hospital or Atlandi 24 hours after death. Funeral Director: A 2 Accident illed in by the 3 ☐ Sulcide 6 ☐ Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and pieca, and due to the ceuse(s) Medical 29e. Certifier end menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 046314 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Paul V. Pomilla, M.D., 110 Hospital Rd., Suite 310, Prince Frederick, MD 20678 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State MAR 0 8 1999 Registrar



# SEARLDINE A. UTTER

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Geraldine Utter Rae MARCH /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner HARFORD Belcamp Lorien Nursing Home If Under 1 Year If Under 24 Hrs. 9. Birthpleca (State or Foraign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Min 1 M 2 XF 216-76-5773 Yrs 1935 **Director** 64 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Itams 23a or 23a-f show other traumatic avant, the Medical Examinal miss be notified at 1 Yes 20No Directo Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 924 North Stepney Road 21001 Funeral death 12. Was Decedent Evar in U,S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Haalth end Mentel Hygiena. Important: If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Yaar or Dates: 1 Never Married 2 Married Specify: White by 3 ₩ Widowed 4 Divorced Completed 15. Decadent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife In home 8 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Williams Zella Boston P 19e. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Susan V. Morgan (daughter) 3316 James Run Rd. Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Qther (Specify) R.A.Ferris & Co. 3/13 West Chester, PA 22. Nama and Address of Facility
Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licensee Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that causad the leath. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Finat disease or condition resulting In death) /Medical Examiner Examiner ician and buriel-fransit certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Box 68760 physician Physician/Medical the 88 use for 23b. Did tobacso use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 2 signed l by 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed cartificate has 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) 25116 Hospital: Other: 4 Ursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Vanne of Death 28a. Date of Injury (Month, Dey Year) funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending Investigation or Attending s after death. 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 5 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

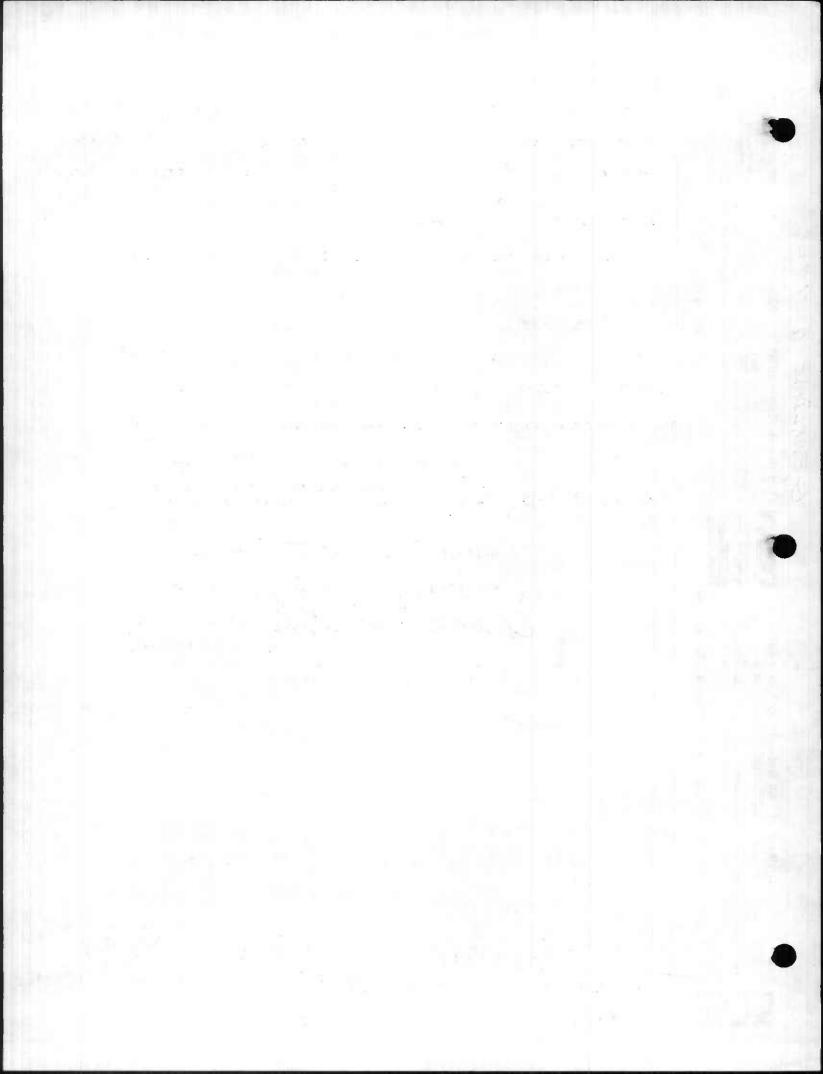
DHMH 16 Rev 6/95

Registrar

Date filed (Month, Day,

MAR

2 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Robert Daniel Vick 1999 March 2:10PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Corsica Hills Nursing Home Centreville Queen Anne 5. Sociel Security Number If Under 1 Yeer if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Mar 3, 1931 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthdey) Birthpiece (State or Foreign Country) **Funeral** Deys Hours 511-26-3185 Yrs. Director Virginia 67 Usuel Residence of Deceden death with the Menyland 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Merylan th and Mental hygiene.

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinating the notified at Md Queen Anne Centreville 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? P.O. Box 50 21617 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 11. Marttel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1☐ Yes 2₺ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest g Eiementery/Secondary (0-12) College (1-4or 5+) Line Worker Manufacturing permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any liqury or other traumatic event. 2005a. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Walter Leo Vick Alma Jean Sharlow 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Frances Ann Vick P.O. Box 84, Goldsboro, Md. 21636 20b. Pieca of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 □XBuriai 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Sharon Hills Mem. Park 3/6/99 Dover, De. 21. Signeture of Funeral Service Licansee 22. Name end Address of Fecility 61 S. Bradford St. Torbert Funeral Chapel Dover, De. 19904 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete intervel Between Onset end Deeth Physician /Medical Immediete Cause (Final diseese or condition resulting in deeth) metastatic lung cancer months **Examiner** Due to (or es e consequence of): Examiner attending physician end for use as the buriel-transit certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): ed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by i 1 Tes 2 No 3 Probably 4 Unknown diabetes mellitus by should I 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? h/o renal cell cancer 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 2 1 inpatient 2 ER/Outpetient 3 DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? After Attending 1 Netural 5 Pending investigation To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Afte completely filled in by the fun. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

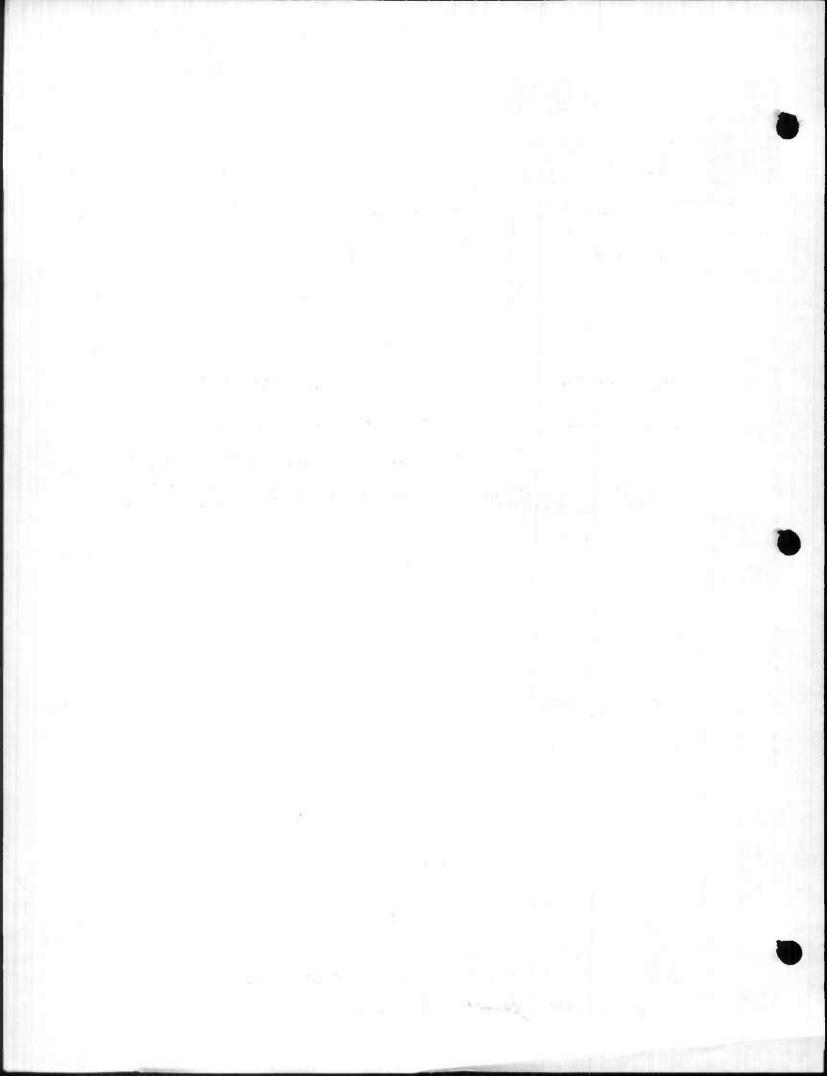
Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D47627 3 - 2 - 9930. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Kathleen Hoey, M.D. 2540 Centreville Rd., Centreville, Md. 21617 31. Date filed (Month, Day, Year) MAR 0 8 1999

State Registrar 2. Registrar's Signeture

P.O. Box 68760.

Records,

Division of Vital



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>D</sup>1<sup>y</sup>999 March 9, **Physician** 0335 Walter Eli Watkins /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Harford Memorial Hospital Havre de Grace Harford Hours Min. 8. Date of Birth (Month Day, Year) 1915 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 M 2□ F Yrs. **Director** 235-07-3220 83 North Carolina Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 11 Yes 2□ No Director MD Harford Aberdeen 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 412 Edmund Street U.S.A. 14. Race - Americen Indian, 21001 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0020 1 Yes 2X No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Shipyard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Watkins UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health e. nt: If tem 27 is . y or other \*\*\* Bernice E. Watkins (Spouse) 412 Edmund Street, Aberdeen, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Department of Important: If any Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Harford Memorial Gardens 3/13/99 Aberdeen, Maryland 22. Name and Address of Facility 21. Signature of Fuperal Service Licensee 0 5 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on eagy line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medicai the Due to (or as e consequence of): use 23b. Dtd tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Watkins, Walter 1 Yss 2 No 3 Probably 4 Unknown A 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Completed page 2 1 TYes 2 € No 1 TYes 2 No. funeral diractor, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

daath. Director within 24 hours

> State Registrar

edicai

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 Natural

2 Accident

3 Suicide

29a, Certifier

4 - Homicide

(Check only one)

5 Pending

investigation

6 Could not be

RI dE los SANTOS MAR 1 2 1999

30. Name and address of person who completed ceuse of death (item 23a) (Type, Print)

M. N. 2835 atture tille Road. Otherchoilly, transford. 32 Registrar's Signature

W,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

11 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

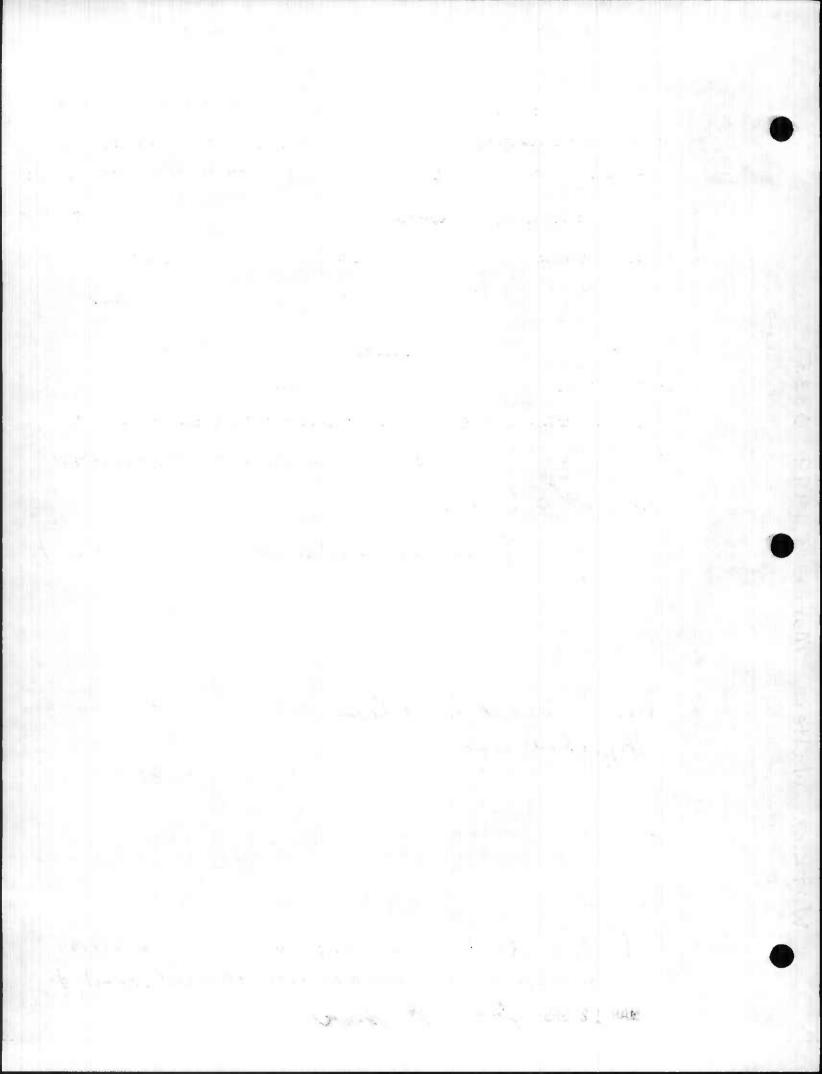
29c. License number

D14036

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Allen Bullock Wilson March 12, 1999 0605 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1₩M 2□F 242-24-3622 77 Yrs. 1921 Director May 4, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits

than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at after filed within Hygiene. other than

permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygiens Important: if Nam 27 is marked other than any injury or other treumstic aware see.

Saltimore, Maryland 21215-0020

2090

A Pro

**Physician** /Medical Examiner

attending physician and I for use as the burial-transit Physician/Medical signed by the a à Completed certificata director, Be deeth.

Funeral To the Hosp within 24 hou To the Fune completely fil

P.O. Records, Division of Vital Attending Physicien:

Medical Certification: To filled in by the f 3 Suicide 24 hours efter of 4 ☐ Homicide 29a. Certifier

> State Registrar

29b. Signature and title of certific

Abingdon Director Maryland Harford 1 ☐ Yes 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 3833 Memory Lane, Apartment C 21009 USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: White 2 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Barber Hair Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louie (UNK) Wilson Sally Tilahman (UNK) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Yvonne McElveen - Niece 2008 Bradford Ct., Tallahassee, FL 32303 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/15/99 Baltimore, Maryland Druid Ridge Cemetery ture of Funeral Service Licensee 22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not res 23b. Did tobacco use contribute to the cause of death? ying cause given in Part I 1 Yea 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 2 X No allen 1 Yes 50 No 25 Was case re examiner? rred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 Ve 2 EFVOutpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1☐Yes 2☐No 2 Accident 6 Could not be

**DHMH 16 Ray 6/95** 

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

who completed cause of death (ftem 23a) (Type, Print)

32. Regist

281. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MC WHITE 7:15 MGR CH,
4b. City, Town, or Location of Death , 1999 am 6 /Medical 4e Facility Name (If not Institution, give street end number) 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL SOOI LOCH RAVEN BLUD Baltimore Baltimore City If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) If Under 1 Year Birthplaca (State or Foreign Country) Social Security Number 6 Sax **Funeral** Months Days **1** M 2□ F Director 217-46-1127 Dec. 30, 1948 Maryland Usuel Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MYes 2 No Director MD Harford Aberdeen the 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 77 Swan Street 21001 U.S.A. Funeral 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 250 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. Never Married 2☐ Married Maryland 21215-0020 1 Yes 20XNo Specify: Specify: p Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) filed within 7 Hygiene. College (1-4or 5+) Elementery/Secondery (0-12) 10 Laborer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi Raymond McWhite Ola Davis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum Joseph McWhite (Brother) 77 Swan Street, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Calvary Methodist Cem3/11/99 Aberdeen, Maryland 21. Signature of Funtiral Service Licensee 22. Name end Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 enuly 23a. Part1. Enter the disease, or complications that gauss the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequence of): Box 68760, Due to (or as e consequence of) signed by the a Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown IMMUNODEFICIENCY Division of Vital Records. by 24b. Were autopsy findings evailable prior to 24a. Was an autopsy Completed completion of cause of death? The law has 1 Yes 2 No 2 No certificate 1 Yes i or Attending Physician: after death. Director: After this certifica funeral director, 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Dete of Injury (Month, Day Year) 27. Menger of Death 28h Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 (Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation the 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide • Funeral C 29a. Certifier (Check only one) 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted. To the Hosp within 24 hor To the Fune completely fi Medical 2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end plece, end due to the ceuse(s) and manner stated. 29c. License number 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) 10 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

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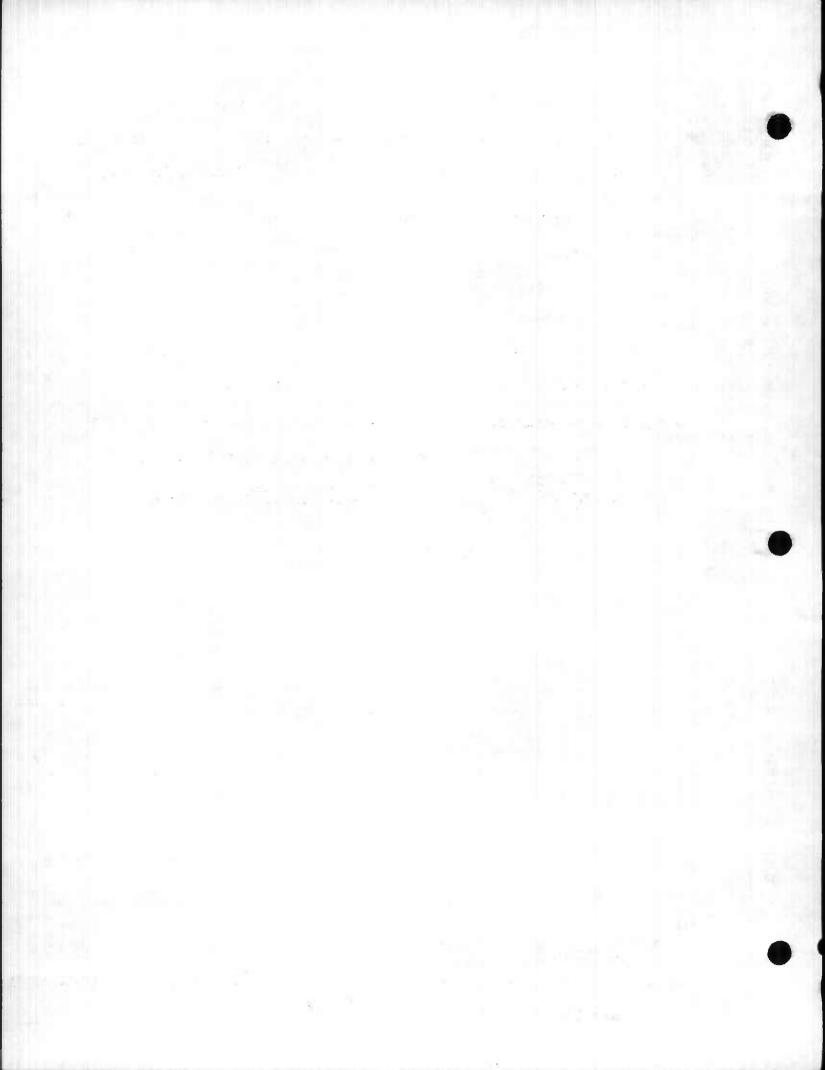
State Registrar Dr JAMUEL

31. Date filed (Month, Day, Year)

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32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 9 9 0 9 1, 9 2

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/Medical Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of Deeth	A	ath
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Men of He	20a. Method of Disposition		<ul> <li>b. Plece of Disposer</li> <li>cemetery, cr</li> </ul>	position (Neme of remetory or other p	(ece)	Dete	20c. Location - City o	r Town, Slete
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

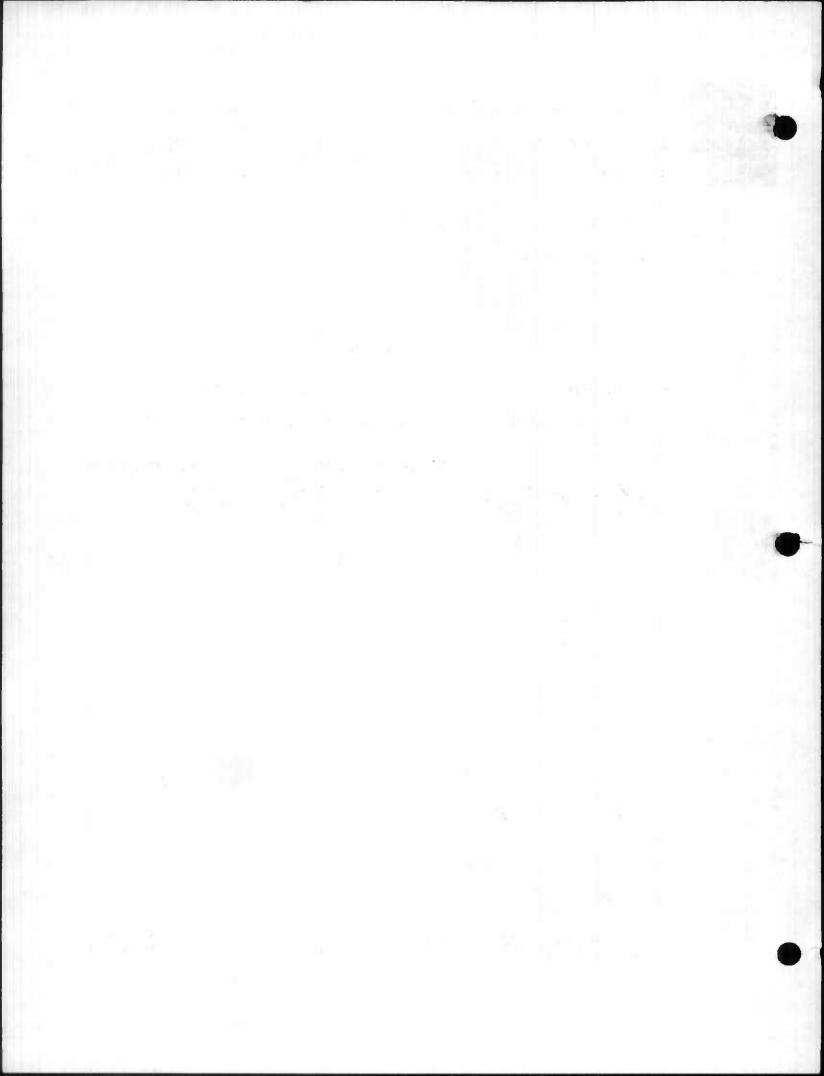
OR TATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
GISTRAR	CERTIFICATE OF DEATH	REG. NO.

		CERTIFIC	ATE OF	DEATH	MENTAL	REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last	)				2. DATE OF	OEATH DAY	YEAR	3. TIME OF O	EATH
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4. SOCIAL SECURITY NUMBER	The second secon	MO	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF (Month, D		8. BIRT	HPLACE (State of	r Foreign
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10e. STATE 10b. COUN	TY	10c. CITY, T	TOWN OR LOCAT	ION				10d. INSIDE C	YTY
Maryland Oue	en Anne's	Cent	trevill	6				LIMITS?	□ NO
10e. STREET AND NUMBER				ZIP CODE		10g.	CITIZEN OF	WHAT COUNTRY	
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11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? TV YES	IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN?	Specify Yee or No-	_ 14. BAC	E — American I	
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17. FATHER'S NAME (First, Middle, Last)		_ cascoute	411	18. MOTHER'S NA		Board of		ation	
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19e. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	ODRESS (Street e	nd Number or Rural			Zip Corini		
Marie W. Whittico	Wife			ntrevill			21617	7	
20e. METHOD OF DISPOSITION	20	b. PLACE AND DATE OF D	DISPOSITION (Ne	me of	OATE	20c. LOCATION			
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* Kandoshi	P. Moore			Funeral					
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Frankly P. March Land Garage

State of Maryland / Department of Health and Mental Hygiene

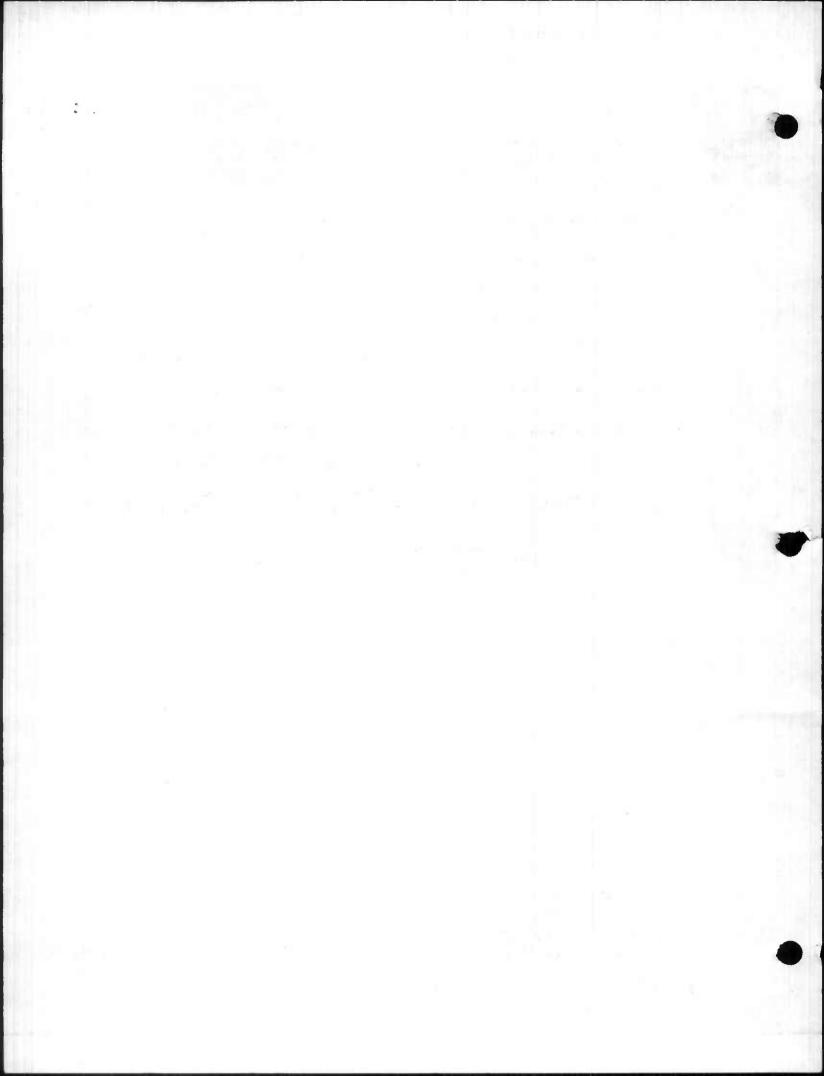
		Decedant's Nama (First, Middla, Las		Ce			Death		Reg. No.		3. Time of Death
Physic		Tona M. Windon						Month	Day	Year 1.000	
_/Medi		4a. Facility Nama (If not institution, give	street and number)				4b. City, Town, or L	Feb	25		1:10 P
Examir	ner						Easton	Ocation of Death			
		Memorial Hospit  5. Social Security Number 6. Se		An una tant historia	a lf Llod	ar 1 Yaar	If Undar 24 Hrs.	To Date of Die	Talbe		
Funeral Director				(In yrs. last birthday	Month		Hours Min.	8. Data of Birt (Month, Day Feb 22	y, Year)	West	ace (Stata or Foreigny) Virginia
show	_	10a. Stata 10b. County		10c. City, Town or I						10	d. Inside City Limit
o Me	cto	Maryland Carolin	e	Goldsbo	ro						1 ☐ Yaa 2 ☑ N
or 2	Director	10e. Street and Number				ip Coda			10g. Citizen of	What Count	ry?
23°	0	26059 Goldsboro R	oad		2	1636		Ţ	JSA		
should be filed within 72 hours efter death with the Maryland and Mental Hyglene.  marked other than "netural", or items 23e or 28e-f show immite avent, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Navar Marriad 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedant E Armed Forcas? 1 ☐ Yas 2 ☒ N If Yas, Giva Yaar or Datas:				lispanic Origin? (Sp an, Maxican, Puarto Spacify:	pecify Yas or No- Rican, atc.)	14. Ra Bla Specia	ce - Amarice ck, Whita, a	tc.
2 hou	P	15. Decedant's Edi	ucation	18a. Dec	edant's Us	ual Occup	pation		16b. Kind of B		
iene. than "ne than "ne	Completed	(Specify only highast grad Elemantary/Secondary (0-12) 8yrs	da complated) College (1-4or 5-	-}	a kind of w DO NOT Homen		ation during most of work d)	king	100.11.10		
Hygir Hygir ent,		17. Fathar's Nama (First, Middla, Last)					18. Mothar's Nam	a (First, Middla,	Maidan Sumai	na)	
2 should be f end Mental F is marked of raumatic ave	To Be	George T. Malnar						rk Maln			
M Pund M	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mai	ling Addra	ss (Street	and Number or Rui			State. Zin	Code)
2000		Mary Pavlovsky/				,	oro Road		oro, MD		
- 4 5 5		20a. Mathod of Disposition 1 □ Burial 2 □ Cramation 3 □ I		20b. Place of Disp cematary, co				Data	20c. Location		
tant:		4 ☐ Donation 5 ☐ Othar (Specify,		William				3-2-99	Frankfo	rd W.	Va.
permit. Peges Depertment of H Important: If ite any injury or of		21. Signatura of Funaral Sarvice Licens	Elevel	F	leeg1	e & 1	ss of Facility Helfenbei 60 Greens				
Physician /Medical Examiner		23a. Part1. Entar tha diseasa, or comp shock, or heert feilura. List only o Immediate Ceuse (Final diseasa or condition rasulting in death)	a	tha death. Do not enal.	PDS	is	ng, such as cardiac	or raspiratory ar	rest,		Approximata Interval Batween Onsat and Death
ted nsit	Examiner		b	1 - 10 SEW 123	-						
tificete be executed ig physician end as the bunel-transit	al Exar	Sequantially list conditions, if any, leading to immediate causa. Entar Undarlying Ceusa (Disaasa or Injury thet Initieted avants	c	oua to (or as a conse	iquance of	):					
\$ 0 K	/Medical	rasulting in daath) Last	d	ua to (or as a conse	quance of	):				i	
atten etten for u	Physician/M									1	
the character the de	ysic	Pert II. Other significant conditions co	ntributing to death but	not resulting In tha	undarlying	cause giv	en in Pert I.	23b. Dld t	obacco use co	ontribute to	the cause of deat
ures that the death cer signed by the ettendir id be detached for use	by Ph							1 🗆 1	708 2 No	3 Prob	ably 4 ☐ Unkno
sw request speen 2 should	Completed								an autopsy mad?	ava	ra autopsy finding ilabla prior to aplation of cause eath?
The lew sete hes pege 2	E							101	as 2 No	10	Yes 2□ No
	0	25. Was casa rafarred to madical					26. Placa of Deal	th (Check only o	/ \		
	OB	axaminar?	Hospital:	t 2 ER/Outpatie	ent 3⊓r	OOA Oth	or.			nar (Specify	)
After fune	ation: T	27. Mannar of Death  1 SNatural 5 Panding 2 Accident Invastigation	28a. Dsta of Injury (Month, Day	28b, Tima		28c. Injury at Work?  28d. Dascribe how injury occurred					
하는 것 같	Certification:	3 ☐ Sulcida 6 ☐ Could not be 4 ☐ Homicida	28a. Place of Injur building, etc.	y - At homa, farm, s (Specify)	treat, facto	ory, office		28f. Location (S City or Tow		ber or Rural	Routa Number,
e Hospital 124 hours e Funeral detely filled	edical	29a. Certifiar (Check only one) 1 Certifying Phy 2 Medical Exami	sicien: To the best of ner: On tha basis of a and mennar stat	xamination and/or I	th occurre	d at tha tin	na, data and place, pinion, daath occur	and dua to tha cred at the tima, o	causa(s) and m deta and place,	anner as ste end dua to	eted. the ceuse(s)
To the within 2 To the comple	Me	29b. Signatura and titla of certifiar	1.1.		2	9c. Licans	a number	T	29d. Data signe	ed (Month, D	Day, Year)
->=0		05-0	AH	MD		)475	34		2/	26/9	9
		30. Name and eddress of person who co	D. 9	eth (Item 23e) (Type 20 Market	Print)	Dent	on MO	21629			
Sta Registr		31. Data filad (Month, Day, Year)	32. Registrar	's Signature	loo	11					



State of Maryland / Department of Health and Mental Hygiene (

			Certificate of	Death	Reg	. No.	0.3	1.0.0
Physician	Decedent's Name (First, Middle,)	Last)			2. Dete of Death Month	Day	Year 3.	Time of Death
/Medical		Newcomb Bart	rum Webb		Mar. 10			3.25 pm
Examiner	4e. Facility Name (If not institution, g	give street and number)		4b. City, Town, or Lo	cation of Death	4c. County	of Deeth	
	Chesapeake Wo	ods Center		Cambrid	ige	Do	rchest	er
uneral		Sex 7. Age (In yrs. I	Months Days	r If Under 24 Hrs.	8. Dete of Birth (Month, Day, Y	ear)	9. Birthplace	(State or Foreign
rector	215-20-4495	73	Yrs.		July 27	, 192	5 Mary	land
1.	Usuel Residence of Decedent  10a. State 10b. County	10c. City	. Town or Location				10d le	side City Limits
Director	Maryland Dorch	,	Cambrid	7.0				Yes 2 No
be notified Director	10e. Street and Number	TEDCEL	10f. Zip Code	<i>y</i>	40-	Ohi		
3 5	510 Danston C	` <del> </del>		61.0	100		What Country?	
miner must b	510 Burton S			L613	o'A. Van as Na	_	S.A.	dian
E S	1 Never Merried 2 Married	12. Was Decedent Ever In U, Armed Forces? 1 Yes 2 No	If Yes, specify Cul	Hispanic Orlgin? (Spe ban, Mexican, Puerto	Rican, etc.)		e - American Ind ck, White, etc.	gian,
by 6		If Yes, Give Year or Dates:	1☐ Yes 2【XNO	Specify:		Specify		
			16a. Decedent's Usual Occu	unation	16	h Kind of Ru	Whit usiness/Industry	
Completed	(Specify only highest of	grade completed)	(Give kind of work done life. DO NOT use retin	during most of workingd)	ng	D. KING OF BU	usiness/industry	
E	Elementary/Secondery (0-12)	College (1-4or 5+)	Homemal			Own I	Homo	
		st)	nomemar	18. Mother's Name	(First, Middle, Ma			
Be G	Oliver Otis N	Iewcomb			Traver		/	
P	19a. Informent's Name/Relationship		19b. Malling Address (Stree				State Zin Code	<b>1</b>
						-		
	Nancy Lee Bart 20a. Method of Disposition 12 Burial 2 Cremation 3	rum/Daughter	ace of Disposition (Name of	ton St,	Cambri	dge,	MD 21	613
6								
ingury 4	4 Donetion 5 Other (Spec		eenlawn Ceme		14-99	Cambi	ridge,	MD
SDCS	21. Signature of Funeral Service Lic		22. Name and Addr	2 common 1 1	Funeral	Home	a. P A	
	23a. Part1. Enter the disease of co shock, or heart failure. List on	rad Donewe	ll 308 High	St. Ca	mbridge	MD	21613	•
	23a. Part1. Enter the disease of co shock, or heart failure. List on	mplications that caused the death ty one ceuse on each line.	. Do not enter the mode of dy	ing, such es cardiec o	r respiretory erres		Appr	roximate vat Between
cian							Onse	et and Deeth
ical iner	Immediate Cause (Finel disease or condition	Metastali	c Cancer of	FThe C	400/0		11	months
	resulting in death)		es a consequence of):					
Examiner		h						
edical Examir	Sequentially list conditions,	Due to (or	as a consequence of):					
	Cause (Disease or Injury	C						
Medical	that initiated events resulting in deeth) Last	Due to (or	as a consequence of):					
2		d						
eteched for us Physician/		<b>U</b> .						
/sic	Part It. Other significent conditions	contributing to death but not resu	lting in the underlying cause g	iven in Part I.	23b. Did tobe	cco une cor	ntribute to the	cause of death?
be deteched by Physic					1 Tes	2 No	3 Probably	4 Unknown
þ								
page 2 should					24a. Was an o		24b. Were au avallable	topsy findinga prior to
mple			<u> </u>				complet of death	ion of cause ?
E O					1 ☐ Yes	2 X No	1 ☐ Yes	2 No
o Be C	25. Wes case referred to medical			26. Place of Death				
To E	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3□ DOA OI		ne 5 ☐ Residend	a 6 Oth	er (Specify)	
	27. Manner of Deeth	The state of the s	28b. Time of 28c. Inju		28d. Describe how			
Certification:	1 Naturat 5 ☐ Pending investigati			Yes 2 No				
by the	3 ☐ Suicide 6 ☐ Could not determine	d 256. Placa of thjury - At nor	ne, farm, street, factory, office	2	28f. Location (Street		er or Rural Rou	te Number,
Medical Cert	4 🖂 Homicide	building, etc. (Specify)	,		City or Town, S	State)		
ai	29a, Certifier 1⊠ Certifying F	hysician: To the best of my know	riedge, deeth occurred at the f	ime, date and place, e	and due to the caus	se(s) end ma	nner as stated.	
edical	(Check only 2 Medical Exit	aminer: On the basis of examination and manner stated.	on and/or Investigation, In my	opinion, death occurre	ed at the time, date	and place, a	and due to the o	ause(s)
Σ	29b. Signature end title of certifier	11 1	29c. Licen	se number	29d	Dafe signed	d (Month, Day,	Year)
	May 1 89	Warth and	00	0 (2 10	0	1	11 100	10
	20 Name and did the U	ceeder (ns)	000	05317	Q IN	Arch	11,190	17
	30. Neme and address of person who		23a) (Type, Print)			0 1		
0.	31. Dete filed (Month, Day, Year)	23 Basistrata Signatura	RN ST SUITE	, Cambrid	186 140	2161	3	
State gistrar	MAR 121	32. Registrer's Signatu	G. Spars					
	MAR IZ	333	1. spark	2				
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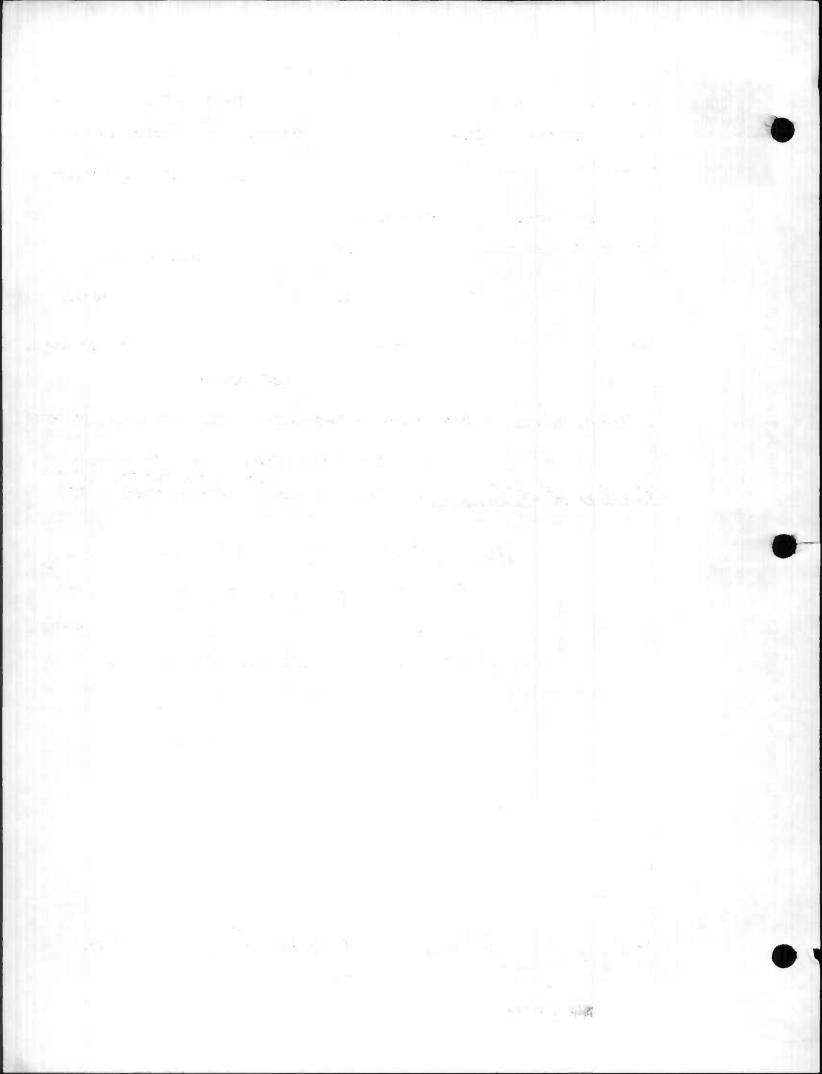
DHMH 16 Rev 6/95



		1. Decedent's Name	e (First, Middle, L	ast)	-		rtificate of	Dealii	2	. Dete of De	Reg. No.		3. Time of Deeth
	sician edical	Ruth	Thelma	Waidma					1	March	2, <sup>D</sup> <b>Y</b> 999	Yeer	6:30 PM
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72 hours after natural", or its	by Fe	1 ☐ Never Merrie 3 ☐ Widowed	ed 2 Married	1 Yes	2 XXIII Give Detes:		1□ Yes XX No	Specify:			Specia	y: W	hite
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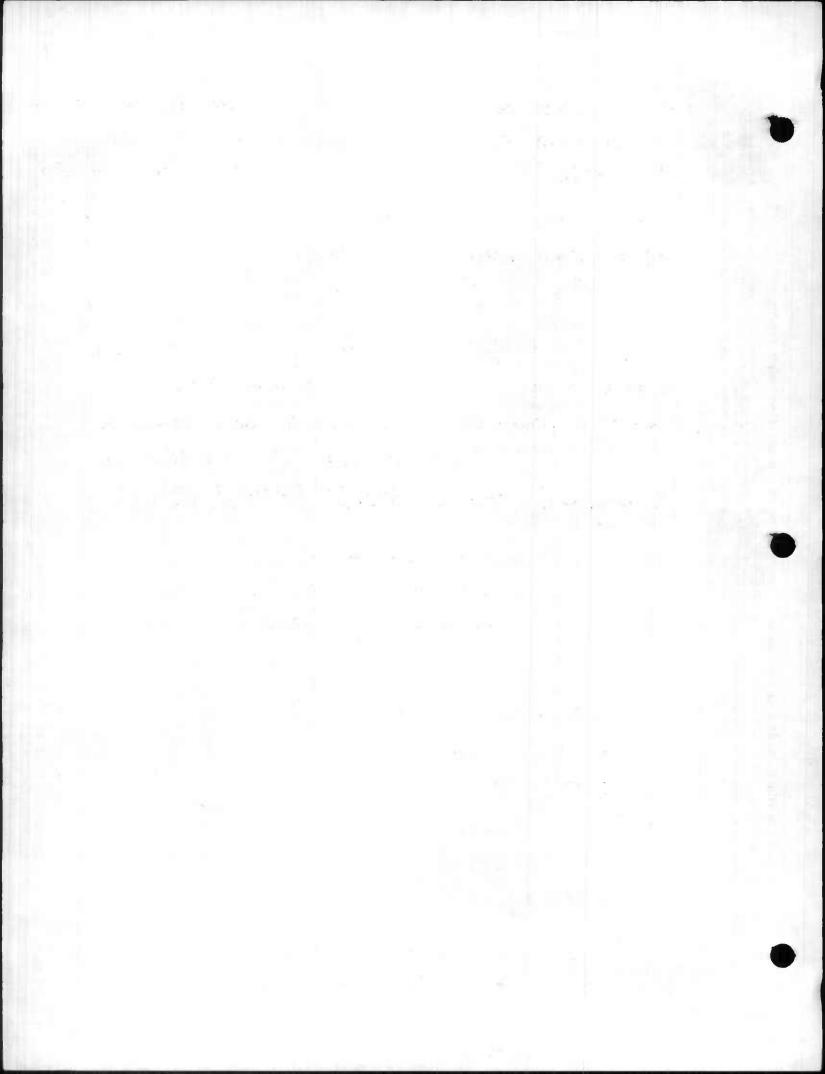


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q AMEND ITEM #8FH G798 8/28/01 JH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 130 Month **Physician** JULIEN ANTOINE 03 19-99 RUDOLPH PM /Medical 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA STAMFORD ROAD BALTIMORE If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number 6. Sex. 7. Age (In yrs. lest birthday) 8. Data of Birth 7-25-3 1 9. Birthplace (State or Foreign (Month, Dey, Year) 5-3 1 (Ountry) **Funeral** Days Months Hours 10 M 20 F 577-18-974 68 TRINIDAD Director Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itama 23a or 28a-f ahow the Medical Examiner must be ruttiled at 1 Yes 2 No NIA Director BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21229 123 STAMFORD ROAD USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedant Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hyglene.
Int: If item 27 is marked other than "natural; or item
Inty or other traumatic avent, me Medical Emericans 1 Never Married 2 Married ☐Yes 2 No Yes, Give Specify: BLACK 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: S 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) NEWS PAPER PRINTER GED 17. Fethar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be ZEDRIANA CHARLES LAWRENCE ANTOINE 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 STAMFORD RD. DENISE STOUT DAUGHTER BALTO. MD. 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or 3.24.99 BALTO. MD 4 ☐ Donation 5 ☐ Other (Specify) MERO CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part. Enter the disharm, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart patters. SERVICE MD 21229 Approximate Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner nc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseesa or Injury that initiated events resulting in death) Last physicien end s the burial-tran requires that the death certificate be execu P.O. Box 68760. dia c Physician/Medical Dua to (or as a consequence of): attending p signed by the all d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Minknown Records, g 24b. Were autopsy findings aveilable prior to completion of ceuse of death? Completed 24a. Was an eutopsy page 2 certificate has 2 No 1 Yes 2 No 1 ☐ Yes een Division of Vital 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 D Natural the funeral 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending P. 124 hours after death.
 Funerel Director: After til After t 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Routa Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 | Homicide 24 hours \*Certifying Phyercian: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29a. Certifier edical To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print). lli lo Agrille 32. Registrarie Olgnature 1999 State

Registrar

DHMH 16 Rev 6/95

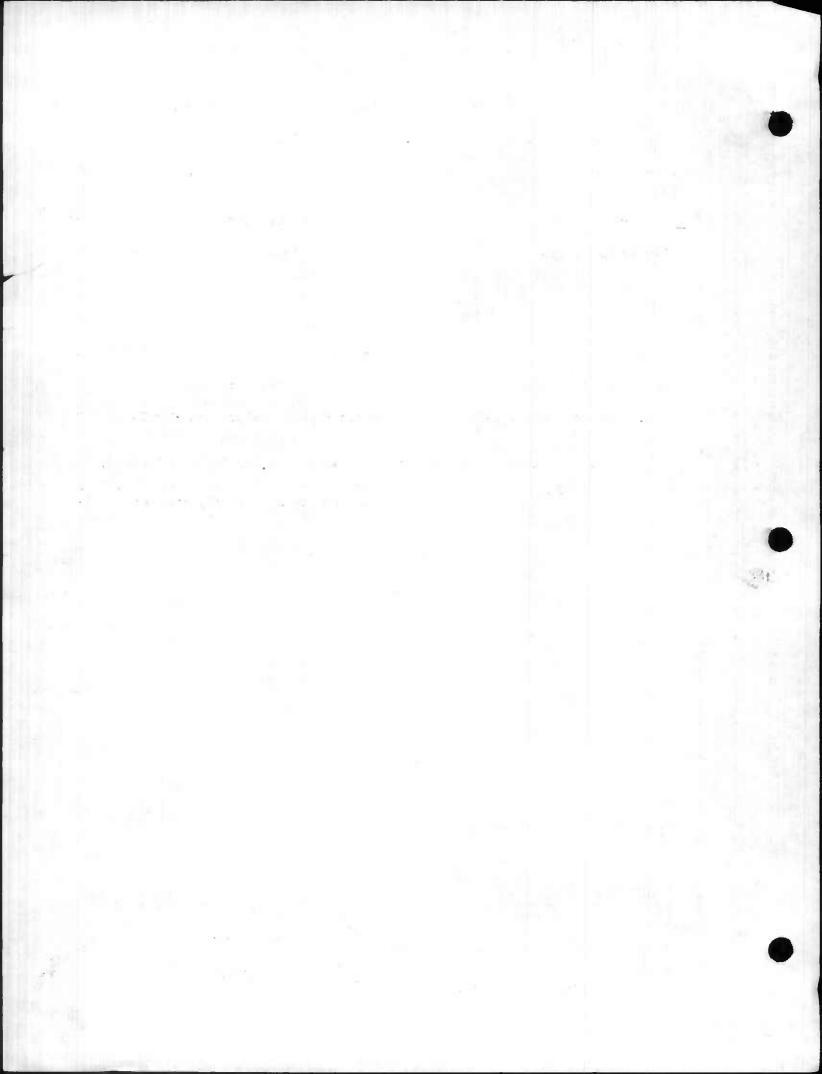


State Registrar 31. Date fited (Month, Day, Year)

MAR 2 4 1999

**DHMH 16 Rev 6/95** 

30. Name and address of person who completed cause of death (florn 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) **Physician** 6. ertrude 8 A.m. CLANDER 99 11 /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** Balto Bidde of 2519 €. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplece (State or Foreign Country) Months Deys Hours Min 1 M 2 F 10 6473 86 Yrs. 5.C Director Usuel Residence of Decedent the Manyland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other treumatic avant, the Medical Examinatory and contract. N.A. Ralto. Md. 1 No Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U. 5. A BiddLe 21213 2519 Funeral 12. Wes Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Self Elementery/Secondary (0-12) 124 House wife 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be VIM Bowler SELINA ROBINSON 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. tnforment's Name/Reletionship (Type, Print) 4901 ST. Georges are Balto, md. 21212 BUCLAL BROW N 20b. Plece of Disposition (Neme of cemetery, premetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) artestus ARbulus 3/25/94 Mem. 21. Signature of Funerel Service Licenses 22. Name end Address of Fecility IN 3/4 1304 h Central Locks 23a. Pent. Enter the disease, or complications that caused the deeth. Do not other the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** Atheroscherotic cardio vasular diterre /Medical tmmediete Ceuse (Final diseese or condition resulting in deeth) Examiner Byperten (10n) Examiner Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Age

Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use a Pert II. Other algniftcant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Ctrebroussalar disense 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown pA 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? ANGINA DECYDRIS 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 Yes 22 No Attending Physician: 25. Wes cese referred to medical exeminer?

1 Yes 2 1 Mo 26. Place of Deeth (Check only one) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending a Funeral Diractor: After the funeral Diractor: After Metally filled in by the fun 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 6 29a. Certifier 1 [P Certifying Physicten: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and manner as steted. within 24 hor To the Fune completely fi Medicai (Check only one) 2 Madical Examtner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and dua to the ceuse(s) end menner stated. 29d. Dete signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) MB 545 COTT ADAM Rd Cockeysulle ud 2130 LA Wrence BUAS

State Registrar

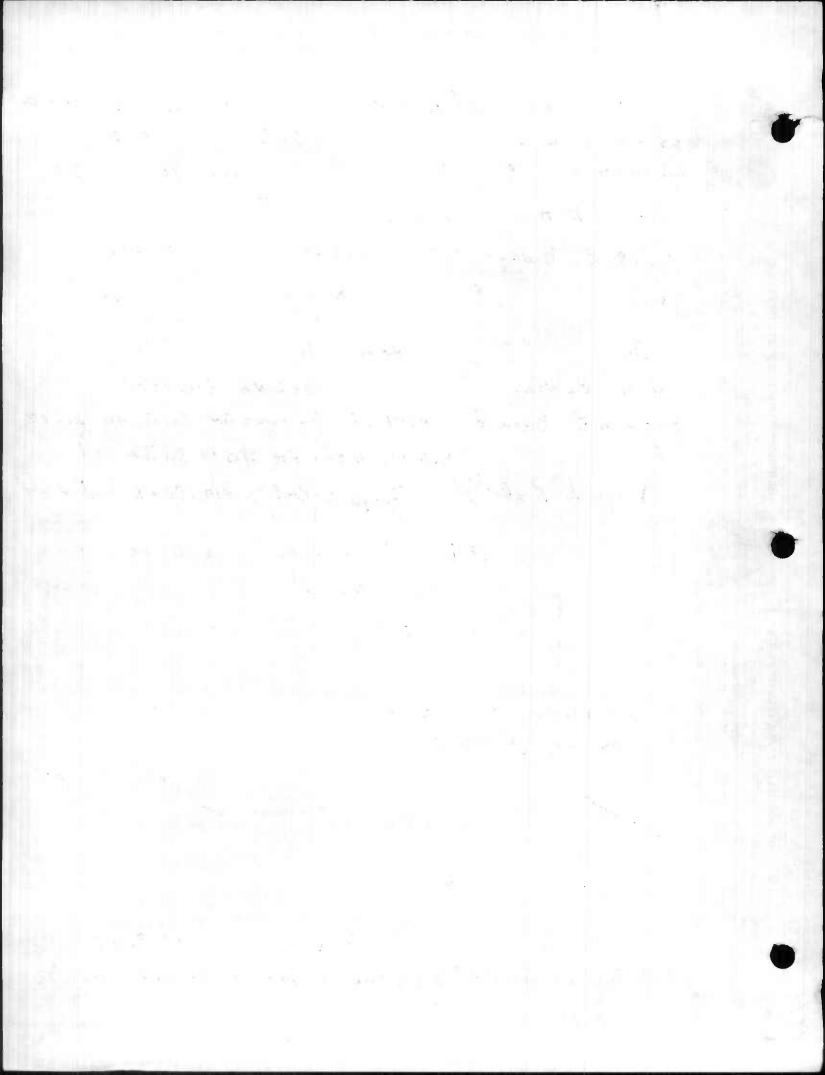
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31. Dete filed (Month, Dey, Yeer)



b. Sports

DHMH 16 Rav 6/95



3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

24b. Were autopsy tindings available prior to completion of cause of death?

1 ☐ Yas 2 ☐ No

15 Hours

1 Yes 2 No

MAryland

21221

5:39 P.M.

**Physician** /Medical Examiner

LIMEY

Maryland

Baltimore,

and Box 68760 Records, P.O. Division of Vital After death.

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** BESSIE E ALTMEYER MARCH /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** osedA BAITIMORE SQUARE Hospilal Center 7. Age (In yrs. last birthday) If Undar 24 Hrs. 5. Social Security Number If Under 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 220-22-6709 10 M 20 F 76 Director Feb 2 1923 Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 28a-f show Md Baltimore ESSEY Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21221 918 Orems Road USA Herns 23a 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 11 Marital Status filed within 72 hours after thygiene. 1 Never Married 2 Married Specify.White 1 ☐ Yes 2 € No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 7th Department of Health and Mental Hygie Important: If Item 27 is marked other the any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental John H Gardner Lenora Stallings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 918 Orems Road Michael Altmeyer/husband Baltimore Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/25/99 Holly Hill Cemetery Baltimore Md. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licenses 22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 23a. Part1. Enter the disease, or complications that caused the death Bo not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a. Syncope
Due to (or as a consequence of): disaase or condition resulting in death) Examiner JACHYCARdiA enlRiculAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Q HypoKA/emiA Due to (ovas a consequanca of): by Physician/Medical Melaslalic OVARIAN CANCER Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Anemia, Thrombocy Topenia, PARAXIA Completed 24a. Was an autopsy performed? ATRIAL FIBRILLATION 1 Yes or Attending Physician: 25. Was case referred to medical axaminer?

1 Yes 2 No 8 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 27. Manner of Death 28b. Time of 26d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation Natural 1 Yes 2 No 2 Accident To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) 3/22/99 WD D0053617

DHMH 16 Rev 6/95

State

Registrar

9000 FRANKlin SqUARE DR. BAITIMORE, MARYLAND 21237

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

a consider

NASSEL

MAR 23 1999

DR HASSER 31. Date filed (Month, Day, Year)

